



## **COMPREHENSIVE CARE AND SUPPORT SERVICES ASSESSMENT IN FIVE CENTRAL AMERICAN COUNTRIES**

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## Abbreviations and Acronyms

ACAFEM	Asociación Centroamericana de Facultades y Escuelas de Medicina
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
AUPRIC	Asociación de Universidades Privadas de Centroamérica
AZT	Zidovudine
BCI	Behavior change interventions
CIES	Center for Health Research and Studies
COMISCA	Central American Region Ministers of Health
CSW	Commercial sex worker
CSUCA	Consejo Superior Universitario Centroamericano
Enf.	Enfermera (nurse)
FSW	Female sex worker
G-CAP	Guatemala–Central American Program
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
HIV	Human immunodeficiency virus
IAPAC	International Association of Physicians in AIDS Care
IDB	InterAmerican Development Bank
INCAP	Instituto de Nutrición de Centroamérica y Panamá
INH	Isoniazid
IPSS	Panamanian Social Security System
ISSS	Istituto Salvadoreño del Seguro Social
IV	Intravenous
LAC	Latin America and the Caribbean
Lic.	Licenciado/Licenciada (title given for someone holding a university degree in a subject)
MSF	Médecins Sans Frontières
MSM	Men who have sex with men
NGO	Non-government organization
OI	Opportunistic infection
PAHO	Pan American Health Organization
PASCA	Proyecto Accion SIDA de Centro America
PASMO	Pan American Social Marketing Organization
PCP	Pneumocystis carinii pneumonia
PCR	Polymerase chain reaction
PLWHA	People living with HIV/AIDS
PEP	Post exposure prophylaxis
PMTCT	Prevention of mother-to-child transmission (of HIV)
SICA	Central America Integration System
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAN	National Autonomous University of Nicaragua
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
UMIETS	Unidades Mínimas de atención de ETS
USAC	Universidad de San Carlos de Guatemala
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing



## **Executive Summary**

The United States Agency for International Development Guatemala–Central American Regional Program (USAID/G-CAP) has been working in Central America since 1995 to improve regional response to HIV/AIDS. This effort will be reinforced in the period 2002–2006 after the launch of an international initiative by USAID for an “expanded response.” The new strategic objective, “The HIV/AIDS problem in Central America Contained and Controlled,” includes aspects of comprehensive care and support that were the focus of policy and public awareness and nongovernment organization (NGO) strengthening. The international target for low prevalence countries for 2007 is to “maintain prevalence below 1 percent among 15-49-year-olds.”

This document is the result of a needs assessment on comprehensive care and support for HIV/AIDS conducted in the field in five countries (Honduras, Panama, El Salvador, Guatemala, and Nicaragua) during a three-week period in October/ November 2002. Needs identified will serve as a basis to propose activities to be supported by USAID/G-CAP during the next four years.

AIDS in Central America is primarily a concentrated epidemic among young men but is infecting an increasing proportion of women; it is found for the most part in cities and major economic areas. The Caribbean coast of Honduras is an exception, however, as in this location the epidemic is generalized and affects both urban and rural populations. The main source of transmission is unsafe sex. Men who have sex with men (MSM)(17.5 to 9 percent prevalence of HIV) are severely affected. Female sex workers (FSWs) comprise another affected group (10.3 to 0.3 percent). Honduras is the most affected country, with a male to female cumulated sex ratio of 1.5:1. According to a UNAIDS 2002 report, Panama, Guatemala, and El Salvador have estimated prevalence among adults between 1.5 and 0.6 percent. Nicaragua has a nascent epidemic.

All surveyed countries have enacted laws protecting human rights of people living with HIV/AIDS (PLWHA). They have national AIDS strategic plans which include comprehensive care and treatment and proposals to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) to increase the number of people in antiretroviral (ARV) treatment. The Honduran proposal has been approved.

The social security systems of Panama, Guatemala, and El Salvador are providing the majority of ARV treatments in the surveyed countries. Currently, Ministry of Health systems are increasing the number of people in ARV treatment.

Important constraints exist in the response to care and treatment needs. Honduras, Panama, and El Salvador are involved in complex reforms of their health systems. Specialized care is concentrated in the capitals and major cities in tertiary-level units. Primary and secondary levels of health care lack necessary commitment and often either refer detected HIV cases to specialized clinics or simply ignore the disease. This complicates the possibility of an early diagnosis, especially considering that AIDS in Central America remains a “hidden” disease. Voluntary counseling and testing (VCT) programs still have to be developed in the health services. Complexity of diagnostic HIV tests is an added strain. Prevention of

mother-to-child transmission (PMTCT) of HIV is complicated by low availability of VCT in antenatal care, and low antenatal care coverage of pregnant women. Health programs related to HIV/AIDS (tuberculosis, sexually transmitted infections, and PMTCT) are poorly coordinated.

During the visit, HIV/AIDS diagnosis and testing, clinical settings, primary training of health workers, in-service training, and PLWHA support groups and needs were assessed. A common simple HIV testing strategy has yet to be defined. Availability of testing sites is low and there is no consciousness of personal risk among the population, consequently up to 70 percent of new HIV diagnoses are made in people who are symptomatic or who actually have AIDS.

The Building Blocks Framework for HIV/AIDS Comprehensive Care, developed by The Pan American Health Organization, is the benchmark for standard of care in Central American countries. ARV therapy is concentrated at the tertiary level of the public health and social security systems. Clinic teams have specialists but are insufficiently staffed for the growing demand. Certain gaps exist in opportunistic infection and ARV drug supplies, and lists of available drugs are limited. A “vertical” concept of care focuses on clinical aspects and is deficient in primary prevention and condom promotion among PLWHA. In most settings, PLWHA groups contribute voluntarily to support the clinics.

The curricula for the primary training of health workers are not integrated; instead they are arranged by discipline and are not focused on comprehensive care. The team did, however, find opportunities for modification. With the exception of Panama, in-service training is not organized. There are interesting initiatives, such as the training program at the Hospital del Torax in Honduras, to organize training to expand treatment capacity. Tertiary clinic personnel were supportive in providing training sites, but human resources are lacking. Experts should always accompany training with monitoring and follow-up.

NGOs and groups of PLWHA said they suffer from discrimination by health workers with problems arising from lack of confidentiality and unfounded fear of nosocomial transmission. ARV treatment is their first concern, but once treatment is regularly available, lack of employment and nutrition were other expressed needs.

Three main issues were identified and led to the conclusions in this document:

- Response to comprehensive care needs must be improved
- Health professionals need flexible, effective training in various disciplines
- NGOs and groups of PLWHA should be linked and supported in efforts to integrate PLWHA back into society

It is recommended that USAID/G-CAP play a decisive role in linking actors to explore the best way to apply the Building Blocks strategy to comprehensive care and support. Efforts must address the decentralization of care and treatment services, including promoting or reinforcing training programs. USAID should also reinforce NGOs and support organizations that deal with treatment follow-up, access to work, and improving nutrition.

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## **I. Introduction**

In September 1995, the United States Agency for International Development Guatemala–Central American Regional Program (USAID/G-CAP) signed a five-year agreement for the Proyecto Accion SIDA en Centro America (PASCA). This project was designed to promote policy and public awareness of HIV/AIDS and to strengthen NGO activities. It was amended and extended in March 2000. In September 1996, a seven-year agreement to develop the Pan American Social Marketing Organization (PASMO) was signed to promote social marketing of condoms to decrease risky sexual behaviors, especially among people in high-risk contexts.

In 2001, the Measure Evaluation Project and Tulane University performed an extensive evaluation of the USAID/G-CAP regional intervention,<sup>1</sup> and a transition planning review was proposed after a meeting in San Pedro Sula in January 2002.

The 1997 goal was “enhanced Central American capacity to respond to the HIV crisis.” This goal evolved in 2002 into a more ambitious one: “the HIV/AIDS problem in Central America contained and controlled.” USAID/G-CAP outlined two areas for future programming to begin in FY 2003: 1) surveillance/data for decision-making, and 2) care and support. This document is an assessment of the second area for future action by USAID/G-CAP.

The AIDS epidemic in Central America has not reached generalized levels with the exception of certain areas of the Caribbean coasts, mainly in Honduras. The epidemic is concentrated (but nascent in Nicaragua) and, with effective action, can be controlled.

There has been a slow but constant empowerment of people living with HIV/AIDS (PLWHA); in every assessed country there were active leaders doing what they consider most urgent: saving lives by using antiretroviral (ARV) treatments.

The population is not yet aware of the risks of contracting HIV/AIDS, and there are various cultural elements that make it difficult to create consciousness and to change behaviors. Barriers to overcome are machismo, social violence, guilt, low educational levels, fear, and rejection. Sexuality is based on double moral standards. Men gain in social status through the sexual conquest of women whereas women must remain chaste to be marriageable. Condoms are not being promoted among PLWHA, even in ARV treatment clinics.

Access to ARV therapy has increased markedly in the region since the beginning of 2002 due to the following:

- USAID/G-CAP organized and supported the strategic alliances for access to treatment
- Efforts by the international cooperating community, such as Médecins Sans Frontières (MSF) which campaigns for and treats an increasing number of people
- Price reductions by the proprietary producers, even if not yet generalized

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<sup>1</sup> Transition Planning Review. Measure. March 2002. Measure Evaluation/Tulane University, USAID Cooperative Agreement No. HRN-A-00-97-00018-00

- Increased competition created by the introduction of generic versions of ARV, mainly coming from Indian companies

Governments felt more confident that they could cope with ARV treatment budgets and started increasing their treatment programs, but this was not enough and in itself raised new problems and difficulties. To identify those problems and to propose feasible solutions will be the scope of this document. Different sources of support, both national and international, and obstacles to achieving universal comprehensive care and support for PLWHA must also be identified.

The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) received proposals from all visited countries. Advances towards AIDS control in Central America depend strongly on the number approved, and that will be decided at the beginning of 2003. Several donors are starting to get involved in AIDS care and treatment but have not yet defined a scope of work. This uncertain situation brings a risk of duplication and concentration of resources in a few settings that may impede expansion of care. USAID/G-CAP must be aware of this risk and must program its future involvement with sufficient flexibility to provide its input where it will be most needed or to change it if duplication is foreseen. A well-known strength of USAID/G-CAP is the ability to connect and link different actors. This capacity for coordination must be enforced to achieve the best results.

## **II. Methodology**

### **A. Assignment and team composition**

USAID/G-CAP will design a new HIV/AIDS comprehensive care and secondary prevention service delivery strategy. In October 2002, The Synergy Project of TvT Global Health and Development Strategies, a division of Social & Scientific Systems, Inc., (TvT/Synergy) provided technical assistance to support an assessment of the treatment infrastructure in five countries of Central America—Guatemala, Honduras, El Salvador, Nicaragua, and Panama—with a focus on human resources at all levels. The team leader and a care and support training specialist worked in country for four weeks. Two care and support specialists joined the team in Honduras and Nicaragua and contributed electronically throughout the assessment and reporting process.

The team included:

- Olaf Valverde Mordt, Team Leader
- Miguel Aragon, Training Specialist
- David Wheeler, Clinical Specialist for Honduras
- Mary Guinn Delaney, Nicaragua Assessor
- Maria Mercedes Vides, Logistic Assistant

The team was accompanied at various times by the following:

- Lucrecia Castillo, USAID/G-CAP
- Bertha Gomez, Pan American Health Organization (PAHO) Support Specialist
- Charles Johnson, USAID

The team's work was guided by two objectives per the scope of work:

- 1) Conduct and deliver an assessment report of the HIV/AIDS Comprehensive Care and Treatment and Secondary Prevention situation in Central America.
- 2) Support and provide necessary inputs to a second team, responsible for preparation of a draft activity approval document (AAD) for the new Intermediate Result 3 "Effective and Efficient Delivery of Comprehensive Care for People Living with HIV/AIDS."

### **B. Data sources**

For the assessment, key project documents from USAID/G-CAP and the Latin America and Caribbean (LAC) Bureau were reviewed. Other basic documents consulted include the National HIV/AIDS Strategic Plans; PAHO's "Building Blocks: Comprehensive Care Guidelines for People Living with HIV/AIDS in the Americas"; and "TvT/Synergy Care and Support Assessment Report, February 2002."

Information from interviews and from other relevant documents was gathered from key USAID personnel from G-CAP and bilateral missions; HIV/AIDS national program managers; PLWHA organizations from local NGOs; staff from the AIDS, tuberculosis and sexually transmitted infection (STI) treatment clinics; Médecins Sans Frontières (MSF) and other international organizations; Ministries of Health (MOH); PAHO; UNAIDS, and other donors.

Field trips to Honduras, El Salvador, Panama, and Nicaragua were carried out during the first three weeks of the consultancy. See Annex 2 for a list of people interviewed and organizations<sup>2</sup> visited.

### **C. Data collection tools**

Two tools were used during the assessment: a semi-structured questionnaire to conduct interviews and a rapid form to collect the information at each care center for HIV/AIDS treatment. (For more details, see Annex 3.)

### **D. Strengths and limitations of the methodology**

Direct and semi-structured interviews allowed for first-hand information, close contact with the people involved, and a better understanding of general and particular situations. The main limitation of the assessment was the quantity of work related to the time available to carry it out. In some cases, time allowed for interviews was not sufficient. In general, the people interviewed were extremely cooperative and provided very useful information.

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<sup>2</sup> People interviewed: 57 (Honduras) +24 (Panama) +35 (El Salvador) +46 (Guatemala) +7 (Nicaragua) = 169  
Institutions visited: 24 (Honduras) + 10 (Panama) +14 (El Salvador) + 19 (Guatemala) +6 (Nicaragua) = 73

### **III. Background**

#### **A. General information**

Central America consists of seven countries: Belize, Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica, and Panama. The population of Central America was 37,202,000<sup>3</sup> in 2001. The human development index in 2002 ranged between 0.820 in Costa Rica and 0.630 in Guatemala. The countries were ranked in the following order: Costa Rica (the only one classified as “high human development”) (43); Panama (57); Belize (58); El Salvador (104); Honduras (116); Nicaragua (118); and Guatemala (120)<sup>4</sup>. The last six belong to the category of “medium human development.” Other general indicators are detailed in *The World Factbook*<sup>5</sup>.

This document concentrates on five of the seven Central American countries: Guatemala, Honduras, El Salvador, Nicaragua, and Panama. Costa Rica and Belize will be included in regional training and networking activities, but the program will not finance implementation in those two countries.

#### **B. HIV/AIDS surveillance in the region**

Annex 1 presents selected data about the region’s HIV/AIDS situation based on the UNAIDS 2002 report. There are two main sources of epidemiological information in Central America: HIV/AIDS cases reported to the national AIDS programs of the Ministries of Health and HIV prevalence studies in selected groups.

#### **C. Case reporting to national AIDS programs**

Reported cases grossly underestimate the actual number of people living with HIV/AIDS but nonetheless are important for understanding the general profile of the epidemic. National incidence and prevalence data based on reported cases should be interpreted with caution due to reporting differences among local centers.

The highest number of reported AIDS cases was in Honduras (13,445 in June 2002). The epidemic in Honduras is on the edge of generalization and in certain regions (across the central economic corridor and on the Caribbean coast) has spread to the general population. The female to male ratio in Honduras is the highest in the region (1:1.2 in the last five years), which also explains the relatively high prevalence in children aged 0-4 years (5.13 percent of all reported cases through June 2002)<sup>6</sup>.

The epidemic characteristically affects younger adult age groups. AIDS cases are concentrated mostly among persons 20 to 39 years of age (72.7 percent in Nicaragua, 70 percent in Guatemala, 68 percent in Honduras, 61 percent in El Salvador, and 58 percent in

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<sup>3</sup>UNAIDS. “Report on the Global HIV/AIDS Epidemic.” July 2002. [www.unaids.org](http://www.unaids.org)

<sup>4</sup> UNDP. “World Development Report.” 2002. [www.undp.org](http://www.undp.org)

<sup>5</sup> CIA. “The World Factbook.” 2002. [www.cia.gov](http://www.cia.gov)

<sup>6</sup> Secretaria de Salud de Honduras. *Informe estadístico mensual de la situación de VIH/SIDA en Honduras*, periodo 1985-jun2002.

Panama). The oldest age distribution of declared cases is in Panama, with 52.9 percent over 35 years of age<sup>7</sup>.

In each country, most cases can be attributed to sexual transmission. Transmission attributed to men who have sex with men (MSM), including homosexual and bisexual behavior, is probably under-reported. A higher proportion of men than women have AIDS. Nicaragua declared the highest proportion (33.5 percent MSM, 4.2 males: 1 female cumulative sex ratio)<sup>8</sup> followed by Panama (19.7 percent MSM, 3.2:1 cumulative sex ratio); Guatemala (14.9 percent MSM, 2.8:1 cumulative sex ratio)<sup>9</sup>; and El Salvador (9.64 percent MSM, 2.4:1 cumulative sex ratio)<sup>10</sup>.

Honduras, with a cumulative sex ratio of 1.5:1 since the beginning of the epidemic, declared 7.3 percent of cases among MSM. In every country, the proportion of infected women has increased over time. Bisexual men are believed to act as a bridge to increase infection in women. After Nicaragua, where most injected drug use was reported at the beginning of the epidemic (4 percent), Panama and El Salvador had the second highest injected drug use as a source of infection (2 percent of all cases).

For specific ethnic groups, the highest rates of HIV are found among the Garífuna of Honduras, a group of 200,000 people mainly settled on the Atlantic coast (8.4 percent in a HIV prevalence survey in 1998)<sup>11</sup>. In Panama, reported cases among the Kuna people present a rate that is 45 percent higher than the average for the entire population<sup>12</sup>. In Guatemala in one clinic in the capital, the proportion of cases among ethnic Mayan increased markedly over time<sup>13</sup>. However, information regarding the impact on indigenous communities is scarce and unreliable. The team could not find data about Guatemalan Garífuna or other ethnic groups.

The epidemic is located mainly in urban areas with the exception of the Caribbean coast of Honduras (departments of Atlántida and Cortés)<sup>14</sup>. It follows the major economic corridors—especially in Panama,<sup>15</sup> where it concentrates around the Canal, and Guatemala<sup>16</sup> where it is spreading between the two oceans and across the southern coast. In Nicaragua, the most affected departments are Managua and Chinandega. In El Salvador, 59

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<sup>7</sup> República de Panamá, Ministerio de Salud, Dirección General de Salud Pública, Departamento de Vigilancia (F.P.R.S.E.) Informe acumulativo de la situación de SIDA Años 1984-2002 (Hasta septiembre).

<sup>8</sup> Vigilancia epidemiológica del VIH/SIDA en Nicaragua 1987-2002. (Datos hasta Agosto 2002).

<sup>9</sup> Ministerio de Salud Pública y Asistencia Social. Dirección General de Regulación, Vigilancia y Control de la Salud. Programa Nacional de Prevención y Control de ITS/VIH/SIDA. Reporte Nacional de la Notificación de Personas con SIDA Acumulado de 1984 al 31 de Enero 2002. Guatemala, marzo 2002.

<sup>10</sup> Ministerio de Salud Pública y Asistencia Social. Programa Nacional de SIDA. Vigilancia Epidemiológica del VIH/SIDA Enero julio 2002. San Salvador, El Salvador 2002.

<sup>11</sup> Análisis de la situación y de la Respuesta Nacional en VIH/SIDA en Honduras. ESA Consultores, Agosto 2002, pp 52

<sup>12</sup> Interview with Dr. Gladys Guerrero, Head of Panamá National Aids Program, 10/21/2002.

<sup>13</sup> Interview with Annelise Hirschman, Director of ASI, about the Clinic Luis Angel García 11/2/2002.

<sup>14</sup> Ibidem, Honduras, ESA Consultores, pp 47-48.

<sup>15</sup> Boletín Situación del SIDA en Panamá, Ministerio de Salud, Dirección General de Salud Pública, Programa Nacional Contra ITS/VIH/SIDA. Año 1, Volumen 1, Junio 2001, pp 13-14.

<sup>16</sup> Protocolo Nacional para el tratamiento antirretroviral del VIH/SIDA. Comisión de Acceso a Tratamiento, Programa Nacional de SIDA, Ministerio de Salud Pública y Asistencia Social, Guatemala, Junio 2002, pp 13.

percent of cases are in the metropolitan area of the capital city, followed by La Libertad, Sonsonate, and Santa Ana.

Outside Honduras, where the epidemic has grown steadily since 1992, most cases in other Central American countries have been only recently recognized. In Guatemala 38.6 percent of the cumulative AIDS cases have been reported since January 1999; in Panama the figure is 46.1 percent, in El Salvador 51.2 percent, and in Nicaragua 57.9 percent.

#### **D. HIV prevalence surveys**

Between 1990 and 2001, a number of HIV prevalence surveys were made in each of the Central American countries without a consistent surveillance system. Those surveys addressed specific groups and used different methodologies<sup>17</sup>.

The latest studies among pregnant women have shown an HIV seroprevalence of about 1 percent. Results were higher in Honduras (1999): 1.9 percent in San Pedro Sula, 1.5 percent in Puerto Cortés, and 0.8 percent in Tegucigalpa<sup>18</sup>. In Panama, (region Panama west) in 1997, prevalence was 0.9 percent<sup>19</sup>. In Guatemala in 2000, it was 0.75 percent in the capital city with an overall average of 0.36 percent among 11 studied sites<sup>20</sup>. Finally, in El Salvador in 2000, it was 1 percent in the main maternity hospital. Nationwide figures may be smaller. In Nicaragua data available showed no HIV-positive cases.

Currently, a multisite study on HIV prevalence among vulnerable groups is being completed with the support of Proyecto Accion SIDA de Centro American (PASCA) and USAID. Data will soon be analyzed, but there are provisional figures about female sex workers (FSWs) and MSM (see Table 1).

**Table 1. Preliminary Results of Central America Multisite HIV Prevalence Survey, November 2002**

Percentage of HIV Positive in each country surveyed		
Country	Female Sex Workers	Men who have Sex with Men
Honduras	10.3	13
Guatemala	4.6	11.5
El Salvador	3.9	17.8
Panama	1.9	10.6
Nicaragua	0.6	9

These results show that Central America, especially Honduras, has a concentrated epidemic that has begun to spread to the general population.

<sup>17</sup> VIH SIDA en las Américas. Una epidemia multifacética. OPS/OMS/ONUSIDA. 2001. pp.8-9.

<sup>18</sup> Ibidem, Honduras ESA Consultores pp 52-53.

<sup>19</sup> Ibidem Boletín Panama. pp 15.

<sup>20</sup> Ibidem Protocolo Guatemala, pp 14.



## IV. National AIDS Policies

### A. Social perception of HIV/AIDS

AIDS in Central America remains largely hidden despite efforts to disseminate information regarding modes of transmission and prevention. Until recently, AIDS has been closely associated with inevitable death, homosexuality, and punishment for immoral behavior.

As mentioned previously, there are double standards regarding sexuality. Men gain in social status through the sexual conquest of women, whereas women must keep their virginity for marriage to be considered “socially acceptable.”<sup>21</sup> Men are expected to take risks; women are not entitled to decide about their sexuality<sup>22</sup>.

HIV-positive MSM experience double discrimination and report having difficulty accessing scarce ARV treatments<sup>23</sup>. The feeling of double discrimination is also sometimes present among PLWHA<sup>24</sup>. MSM, male transvestites, and FSWs are disproportionately affected by the epidemic. They constitute bridges that help to transmit HIV into the general population.

Churches have created considerable resistance to the promotion of condom use. PASMO distributed condoms in outlets serving high-risk populations, and a considerable increase in condom use was achieved among FSWs but not among MSM<sup>25</sup>. Behavior change does not automatically follow increased knowledge and availability of commodities and services.

None of the Central American countries has a comprehensive curriculum for sexual education in schools, particularly a curriculum that considers aspects of sexual orientation and that provides information regarding AIDS risks and how to react according to personal circumstances. Sex education, if any, is didactic and leaves no room for open discussion<sup>26</sup>. Important initiatives for open sex education have come from NGOs and universities and have been well received by the students and their families, but they remain isolated. One attempt in Guatemala faced strong opposition from the Catholic Church hierarchy<sup>27</sup>.

PLWHA experience widespread dissatisfaction when they confront the health care systems. In addition to pervasive fear, PLWHA often experience rejection by health staff, prolonged

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<sup>21</sup> El amor en tiempos del SIDA. Documentary film. Isabel Juarez, Alfonso Porras, Olaf Valverde, Luciérnaga, Médicos Sin Fronteras, Unión Europea. December 2000.

<sup>22</sup> Exclusión Social y VIH/SIDA en Guatemala. Cesar A. Nuñez, Sergio Aguilar and Víctor Hugo Fernández. Cuadernos de Desarrollo Humano. 2001, n° 10, pp 10. PASCA.

<sup>23</sup> Interview with Oscar Carrion, Raul Coto, Jeffry Orellana, and Elkin Suarez. Comunidad Gay Sampedrana, October 15, 2002.

<sup>24</sup> We received this comment on various occasions, especially from homosexual PLWHA. Competition for scarce ARV treatments comes as a dramatic consequence.

<sup>25</sup> Transition Planning Review. Measure Evaluation. Tulane University, March 2002.

<sup>26</sup> Maria Dolores Yoc. State of the Art Conference on Sex Education in Central America. CONCASIDA II, November 2001.

<sup>27</sup> A leaflet on sex education addressed to adolescents, supported by PASMO, faced considerable controversy including several articles in the Guatemalan press in 2000. There was an official complaint by the Bishops Conference. One of the most controversial arguments of the leaflet was to state that homosexuality was simply a matter of sexual orientation choice and it was not a disease.

waits in emergency rooms, lack of appropriate care, and broken confidentiality.<sup>28</sup> Surgical care is even more difficult to obtain because of frequent compulsory HIV testing (even if illegal and unnecessary) and refusal on the part of some surgeons to proceed with scheduled operations. Deaths have been reported. Fear of contamination of diagnostic instruments often leads to delayed attention or to no attention at all. Even in national guidelines there are sometimes exaggerated recommendations regarding surgical care for PLWHA<sup>29</sup>. An additional problem found in each country (with the exception of Panama) was that health students and professionals did not want to rotate through the AIDS care sites. When a PLWHA dies, it is common to have an alternative diagnosis listed on the death certificate. Many interviewees agreed that health staff training that included an accurate description of real risks, appropriate protection measures, and universal precautions might reduce the discrimination that often occurs in tertiary care units where AIDS patients are referred.

Fear of the disease, fear of society, and fear of the family lead to silence. Some of the fear may, however, be unfounded. Often, families and close friends react in a supportive way when a person discloses his or her HIV-positive status. On the other hand, there have also been problems in communities with neighbors refusing to buy in PLWHA-owned shops and rejecting members of the PLWHA families even if the members are not HIV-positive themselves.

While interviewing activists and other persons in close contact with PLWHA, a number of instances of subtle or obvious discrimination were recounted. The most feared and frequent was loss of employment or inability to find a new job. There are frequent reports of compulsory testing by employers with dismissal of HIV-positive employees or refusal to appoint HIV-positive new employees. Social workers from the social security systems in El Salvador and Guatemala reported development of a “safety net” that provides for retirement with disability when PLWHA lost their jobs or could not get new ones.

## **B. Legislation**

Every national constitution in Central America guarantees the right to life and, as a direct consequence, the right to health and the obligation of the state to provide health care. In recent years, with the publication of international guidelines for legislation about HIV/AIDS<sup>30</sup>, all countries included in this assessment have enacted specific laws<sup>31</sup>. At least three of them consider AIDS as a social problem of national priority (Honduras), national interest (Panama), or emergency (Guatemala). All of them promote state responsibility for comprehensive care and treatment of AIDS and establish measures to enhance respect for the human rights of PLWHA and to protect them against discrimination.

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<sup>28</sup> El VIH/SIDA desde otro punto de vista. Dr. Orlando Quintero. Revista Medico Científica. 1999, Vol 13, n° 1 y 2, pp 11. Asociación de Estudiantes de Medicina de Panamá.

<sup>29</sup> Protocolos de atención de personas infectadas por VIH. Programa Nacional de Prevención y Control de ITS/VIH/SIDA. El Salvador Abril 2002, pp 132. They recommend using double glove and HIV testing in elective surgery.

<sup>30</sup> Handbook for Legislators on HIV/ AIDS and Human Rights. UNAIDS/International Parliamentary Union, November 1999. The full document can be obtained in [www.unaids.org](http://www.unaids.org).

<sup>31</sup> Murillo G., Stern R. “Breve Análisis de la Legislación en los Países Centroamericanos sobre el VIH/SIDA.” Report to UNAIDS, May 2001.

The laws enacted were the following:

- Costa Rica, Ley n° 7771, April 29, 1998
- Honduras, Ley n° 147-99, September 9, 1999
- Panama, Ley n° 3, January 5, 2000
- Guatemala, Decreto Legislativo n° 27-2000. May 3, 2000
- Nicaragua, Ley n° 238
- El Salvador, Decreto n° 588, November 23, 2001

The most recent AIDS law was approved in El Salvador and proposed to establish a national policy for comprehensive care in six months. The law originally included measures allowing compulsory testing of employees,<sup>32</sup> but this paragraph was subsequently removed<sup>33</sup>.

The AIDS laws have yet to be disseminated and enforced. Sources in Honduras indicated that compulsory testing for employment is still widely used as is the case in other countries. Availability of appropriate treatment is still limited by health resources and budgets. Panama is the only country included in this assessment with high ARV treatment coverage. Guatemala and Nicaragua include national and foreign patients among beneficiaries. All countries make no distinction between the insured and the uninsured for accessing appropriate care.

ARV treatment has been introduced in Central America often after legal injunctions to governments from PLWHA. Once ARV treatment was introduced in Costa Rica, the Association PROBIDSIDA in Panama (directed by Dr. Orlando Quintero) requested ARV treatment from the Panamanian Social Security System in 1999. After an initial rejection by the Supreme Court, street demonstrations led to negotiation and approval of treatment. In El Salvador, after a formal complaint by a group of PLWHA led by Odir Miranda, the Interamerican Commission for Human Rights requested the social security system to start providing treatment in 2001. The Salvadoran Ministry of Health offered ARV treatment in January 2002.

In Honduras a passionate plea to the parliament by activist Rosa Gonzalez in September 2001 led to a special emergency budget and to larger sums to buy ARV drugs in the year 2002. In Guatemala, the social security system started generalized ARV treatment among its beneficiaries in 1998. The Asociacion Coordinadora de Sectores de Lucha Contra el SIDA (led by Dr. Cristina Calderón), and groups of PLWHA sued the President in May 2002. In August, he requested the creation on a special fund for immediate treatment and an increased budget for 2003.

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<sup>32</sup> Ley de Prevención y Control de la Infección Provocada por el Virus de Inmunodeficiencia Humana. Decreto n 588 de la Asamblea Legislativa, 2001. El Salvador.

<sup>33</sup> Personal interview with Stanley Terrel, October 20, 2002. Confirmed later by other informants.

### **C. National AIDS strategic plans**

Between 1999 and 2001, all countries assessed except Panama produced national strategic plans for HIV/AIDS in a process supported by UNAIDS and PASCA<sup>34</sup>. Honduras is reviewing its strategy<sup>35</sup>. Guatemala already has a revised version of the original plan<sup>36</sup>. The new Honduran government showed increased commitment by introducing specific targets in its Government Plan for the Health Sector 2002–2006. Among the targets, the Honduran plan aims for 90 percent detection of HIV/AIDS cases and at least 3,000 people on ARV treatment<sup>37</sup>.

In general, all plans describe either introducing or increasing comprehensive HIV/AIDS care, training health professionals, strengthening and decentralizing treatment services, guaranteeing access to ARV drugs, and promoting community and PLWHA participation. El Salvador and the original plan of Guatemala introduced general budgetary provisions.

The plans were created in workshops that included representatives from the governments and different sectors of civil society and a detailed analysis of the existing situation and national response. The plans were considered in creating country proposals for the GFATM.

### **D. Political commitments and budgets**

In July 2001, the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS became a turning point in the development of a political consciousness of AIDS in Central America. The Honduran Minister of Foreign Affairs outlined the importance of a common regional action and requested long-term international commitment and support. The Salvadoran representative was more precise proposing coordinating mechanisms through the Central American Region Ministers of Health (COMISCA), RESSCAD (including Dominican Republic), and Central America Integration System (SICA), as well as formal regular meetings at a high government level. The Nicaraguan Minister of Health reported her country's lack of available funds to address AIDS and requested international funding. The Guatemalan Minister of Health proposed the creation of a national unit for AIDS treatment with participation of both the government and civil society. All offered to increase their commitment to treatment of PLWHA.

In November 2001, Honduras negotiated ARV drug price reductions with the companies included in the Accelerated Access Initiative. This set an example for the region and stimulated political will for AIDS treatment. A few months later, the Central American heads of state signed the Madrid Declaration, which requested common regional negotiations for price reductions. By mid-2002, several generic drug producers had their ARV drugs registered in several countries, and El Salvador had negotiated a reduction with major pharmaceutical manufacturers.

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<sup>34</sup> Plan Estratégico Nacional de Lucha Contra el SIDA 1998-2001. Tegucigalpa, Honduras, Agosto 1999. Plan Estratégico Nacional de Prevención y Control de ITS/VIH/SIDA 2001-2004, Junio 2001, San Salvador.

<sup>35</sup> Líneas prioritarias del II Pensida 2003-2007, Octubre 2002, San Pedro Sula, Honduras.

<sup>36</sup> Plan Estratégico Nacional ITS/VIH/SIDA Guatemala. Revisión 2002, Agosto 2002, Guatemala.

<sup>37</sup> Plan de Gobierno del Sector Salud 2002-2006. Secretaría de Estado en el Despacho de Salud. Honduras.

Several mechanisms were proposed to expand access to treatment. The ministers formally supported common purchases at the regional level. PAHO has a project to set up a revolving drug fund common to all Latin American countries. It was recommended that this fund be set up for AIDS drugs (including ARVs), as well as drugs for malaria, leishmaniasis, and tuberculosis (TB).

The potential to increase budgets for drug purchases by Central American governments (with the exception of Nicaragua) will be enhanced if the Global Fund proposals are approved. Generic competition and price reductions might also greatly improve access to treatment<sup>38</sup>.

### **E. Global Fund proposals**

Every country assessed presented a proposal for HIV/AIDS to Global Fund for AIDS, Tuberculosis, and Malaria (GFATM). Panama's latest proposal was only for AIDS and El Salvador's proposal included tuberculosis but not malaria. The other countries requested support for all three diseases. In the first round of grants, only the Honduran proposal was fully approved subject to minor changes. The Government of Honduras expects to receive funds early in 2003. Panama's proposal was approved for TB, but the AIDS aspect of the grant had to be resubmitted. The Global Fund will decide on the other Central American country proposals in early 2003 but will not disburse funds before the second semester<sup>39</sup>.

**Honduras.** Under the Honduras proposal, AIDS activities will be concentrated in 39 municipalities covering 48.7 percent of the population<sup>40</sup>. These 39 municipalities were selected because of their higher prevalence of HIV/AIDS. Most infected persons live along the Caribbean coast and the central corridor, which include the two main cities of San Pedro Sula and Tegucigalpa. According to the PAHO Building Blocks strategy, targets for comprehensive care are to be in place in all of the hospitals in the 39 municipalities. After five years, 3,503 people are expected to be on ARV treatment.

Another goal for Honduras is the creation of 390 sites for voluntary counseling and testing (VCT). The national laboratory network will be strengthened. City or local surveillance committees are to be organized to promote respect for the rights of PLWHA (among other functions). There are also plans to create a network of human rights promoters and to train PLWHA groups and families in home-based care. There is no mention of common activities for AIDS and TB.

**El Salvador.** El Salvador plans to develop an integrated response with public, private, and NGO participation<sup>41</sup>. At present, services are concentrated in San Salvador and there are

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<sup>38</sup> HIV/AIDS Medicines Pricing Report. "Setting Objectives: Is There a Political Will?" Carmen Perez Casas. Campaign for Access to Essential Medicines. Medecins Sans Frontieres. June 2000. Presented at Durban XIII International AIDS Conference.

<sup>39</sup> For more information, consult [www.globalfundatm.org](http://www.globalfundatm.org).

<sup>40</sup> Strengthening of the National Response for Protection and Promotion of Health in Malaria, Tuberculosis and HIV/AIDS. Proposal submitted April 2002.

<sup>41</sup> Estrategia de Lucha contra el VIH/SIDA y la Tuberculosis en poblaciones vulnerables como coadyuvante a la reducción de la pobreza en El Salvador. 2003-2008. Proposal submitted September 2002.

obstacles to decentralization. ARV treatment is currently provided only in tertiary level hospitals; the goal is to start it in regional hospitals and at the local level, including mobile diagnostic clinics for VCT. The planned extension of services should cover 14 hospitals by 2008 (four of them in the first year). In the next two years, the plan is to extend ARV treatment to as many as 1,108 people. There is an interest in developing self-support groups of PLWHA to fight against discrimination. Such groups would be important in promoting concurrence with treatment and home-based care. The proposal also considers addressing co-infection with HIV and TB.

**Nicaragua.** The Nicaraguan proposal is based on multisector coordination, comprehensive care, and promotion of human rights, including fighting discrimination against PLWHA<sup>42</sup>. There are plans to train 18 new doctors in comprehensive care and ARV treatment following the Building Blocks strategy of PAHO. Nurses, self-support groups, and counselors would also be trained (120 a year). ARV treatment would begin with 100 people and would increase to 390 after five years. Other targets are to treat 250 people for opportunistic infections and to treat 20 pregnant women by the end of the proposal. Nicaragua wants to increase hospital capacity to treat AIDS in up to six units by 2008; equipment is requested for three of them. Four workshops on the Building Blocks strategy will be conducted each year. Additional centers for VCT, up from six at present, will be developed. There is also a proposal to organize a diploma course on STIs/HIV/AIDS in the National Autonomous University of Nicaragua in Managua (UNAN) in close coordination with the Center for Health Research and Studies (CIES). Regarding TB, they propose to do HIV testing and to administer isoniazid (INH) prophylaxis to HIV-positive persons.

**Guatemala.** Guatemala's April 2002 proposal received favorable comment along with a request for resubmission after modifications. In September, a new proposal was sent to the GFATM<sup>43</sup>. It combines developing treatment centers and centers for training and counseling in six areas of high prevalence. Guatemala will expand referrals to them and will improve STI treatment units. Overall, there are plans to increase care capacity fourfold. Targets are set at 5,200 people on ARV treatment and 8,700 PLWHA in care. Another objective is to increase the coverage of VCT offered to pregnant women from 5 percent to 90 percent of women receiving antenatal care. There are activities programmed for in-service training and specialized studies for mid-level professionals who will manage the regional treatment clinics.

**Panama.** Panama introduced a three-year proposal to strengthen its ongoing system<sup>44</sup>. Regarding care and treatment, the proposal will expand training for health staff (840 targeted) and for PLWHA and their immediate support environment (630 targeted). The plan calls for a 50 percent increase in the purchase of HIV tests to improve coverage of VCT activities. In antenatal clinics, the target is 72,000 women to be screened, 360 HIV-positive women to receive treatment, and an extension of prevention of mother-to-child

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<sup>42</sup> Nicaragua, compromiso y acción ante el SIDA, Tuberculosis y Malaria. Proposal submitted September 2002.

<sup>43</sup> Iniciativa multisectorial para la reducción del impacto del SIDA, Tuberculosis y Malaria en áreas prioritarias de Guatemala. Proposal submitted September 2002.

<sup>44</sup> Fortalecimiento de la prevención, atención y control del VIH/SIDA en poblaciones en condiciones de pobreza, extrema pobreza y comunidades indígenas en Panamá. Proposal submitted September 2002.

transmission (PMTCT) services. A complement of laboratory tests (for CD4+ count and viral load) and ARV drugs is requested to improve coverage (500 supplementary treatments). Beneficiaries are considered as agents for dissemination.

## **F. Access to ARV treatment**

ARV treatment availability changed dramatically in 2002. Every country assessed has expanded the numbers of people on ARV drugs both in the social security and Ministry of Health networks. Panama has the highest coverage as more than 90 percent of HIV-infected individuals qualify; Honduras has less complete coverage.

## **G. Social security systems**

Except for Honduras and Nicaragua, the systems provide ARV coverage to insured persons according to internal guidelines. There are still difficulties in making an early HIV diagnosis, for example in Panama where 70 percent of newly diagnosed cases are symptomatic or have already AIDS<sup>45</sup>.

The Panamanian Social Security System has a good supply of drugs and medical and laboratory equipment. There are 869 people (48 children) on ARV treatment<sup>46</sup>. They have decided to extend triple therapy to PMTCT programs, even if it has to be generalized to the peripheral units.

In Guatemala, there are problems with laboratory monitoring. The new administration has decided to restrict viral load measurements to 40 a month (for adults), even though they have identified 956 persons (including 250 children) on treatment. National AIDS treatment protocols propose two viral loads per person on ARV treatment per year<sup>47</sup>, which means that the system will provide only 30 percent of needed tests. At present, there is a movement to improve follow-up and to introduce rescue ARV drugs for patients in need<sup>48</sup>.

In the Salvadoran system, there were 428 adults, nine pregnant women, and 10 children on treatment as of the end of October<sup>49</sup>. There is an active outreach program to identify HIV in pregnant women and an attempt to decentralize services.

In Honduras and Nicaragua, the systems are unable to cover ARV treatment. The Honduran institute receives drugs from the Ministry of Health budget (see detail in the following section).

## **H. Ministries of Health**

In Central America, Ministries of Health have their own care networks, usually serving the poorest segments of the population.

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<sup>45</sup> Personal interview with Dr. Nestor Sosa, Head of Infectious Diseases Service, IPSS, October 21, 2002.

<sup>46</sup> Interview with Dr. Laura Thomas, Epidemiologist, IPSS, October 21, 2002.

<sup>47</sup> Protocolo Nacional para el Tratamiento ARV del VIH/SIDA. Comisión de Acceso a Tratamiento, Programa Nacional de SIDA, Ministerio de Salud Pública y Asistencia Social, Guatemala, Junio 2002.

<sup>48</sup> Interview with Cristina Calderón, Ismar Ramírez, and Luis Cuscul, Fundación Fernando Iturbide, October 30, 2002. Guatemala.

<sup>49</sup> Interview with Dr. Jose Viana, Infectious Diseases Specialist ISSS, October 25, 2002, El Salvador.

El Salvador started providing ARVs in 2001 and, as of October 2002, 123 adults and 44 children were on treatment. Since January 2001, a project supported by MSF cared for 154 pregnant women<sup>50</sup>.

Panama's Ministry began offering ARV treatment in January 2002. By the end of October, 62 adults and 121 children were taking ARV drugs<sup>51</sup> in Hospitales del Niño and Santo Tomas. Another group of 64 adults was receiving ARV from two studies by a multinational pharmaceutical company.

The Guatemalan Ministry of Health started providing ARV treatment in 1999 to a group of 27 persons who had been part of a study finished by a multinational drug company. The company provides one drug and the government completes the remaining two for triple therapy<sup>52</sup>. Currently, this treatment is being given in a clinic organized by the Association Gente Nueva. No new treatments were offered until July 2002 when, after a formal demand, the President authorized 160 new treatments in Roosevelt and San Juan de Dios hospitals of the capital city, one-half of them to adults and one-half to children<sup>53</sup>. Drug suppliers were selected in a public bid on November 6 to expand the number of people on treatment.

In Honduras, the Congress authorized a special purchase of ARV drugs in October 2001. After a long process interrupted by general elections and a change of government, drugs were finally available for 200 people in July 2002. By the end of October, 800 new treatments had been authorized by the government to be offered in four clinics of the health system, two in the capital (Hospital Escuela and Hospital del Torax) and two in San Pedro Sula (Hospital Catarino Rivas and the Social Security Clinic).

In Nicaragua, there is a crisis in essential drug supply, and the government does not provide ARV therapy.

## **I. Other sources of treatment**

MSF began offering ARV therapy in Roosevelt Hospital in Guatemala in August 2001. Currently, this international NGO provides ARV treatment to more than 270 persons in three different settings in the country<sup>54</sup>. The same NGO started another AIDS treatment program in Honduras in the city of Tela on the Caribbean coast. As of October 2002, 13 persons were receiving ARV drugs<sup>55</sup>.

In the Clinica Luis Angel Garcia of Guatemala, 79 children are receiving treatment under the U.S. program Medicines 4 Guatemala based on a supply of drugs not used in

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<sup>50</sup> Data provided by Dr. Celina de Miranda, National AIDS Program, October 10, 2002, El Salvador.

<sup>51</sup> Data update provided by Dr. Gladys Guerrero, Head of the National AIDS Program, October 21, 2002, Panama.

<sup>52</sup> Reported by Dr. Eduardo Arathoon in his presentation, "Las investigaciones con ARV. Que pasa cuando finalizan" in Proceedings of the 1<sup>st</sup> Central American Conference for Access to Essential Medicines, Antigua Guatemala, June 2001.

<sup>53</sup> Reported by Ms. Dory Lucas, Head of the National AIDS Program, October 29, 2002, Guatemala.

<sup>54</sup> Reported by Dr. Alberto de Dios. Médecins Sans Frontières, Guatemala.

<sup>55</sup> Reported by Dr. Antonio Girona. Head of Mission, Médecins sans Frontières, Honduras.

Guatemala. In addition, 20 adults benefit from a similar program sponsored by the Guatemalan NGO APAES, and 30 more are covered under a study by a pharmaceutical company<sup>56</sup>.

In Honduras, at least four programs provide ARV treatments. The main ones are in San Pedro Sula run by the NGO Juntos por la Vida where more than 100 people are receiving generic drugs<sup>57</sup> and in Tegucigalpa where the NGO Solidaridad y Vida treats 66 persons (12 children)<sup>58</sup>. Other programs such as Puertas Abiertas and Casa Aurora, both in San Pedro Sula are offering ARV drugs.

A program providing therapy from donated drugs exists in Nicaragua; there is no information about parallel systems from El Salvador or Panama.

Until ARV treatment availability by public sources has increased markedly, the main sources are donations, private purchase, or studies by pharmaceutical companies. At present in Guatemala and in Panama, significant numbers of people are benefiting from drugs provided by pharmaceutical companies but face the prospect of uncertain supplies once the studies are finished<sup>59</sup>.

## **J. Regional data and estimated needs for ARV treatment**

No model has been found to estimate the number of people in need of treatment. Several authors propose to enhance the health information system quality (case reporting, seroprevalence data, and second-generation surveillance). This is the best way to have accurate estimates, but there is also a risk of accumulating data without offering adequate care. The limiting factor for extending treatment now is not the total number of people in need, but rather the ability of the health system to cope with existing demand.

All countries assessed in this report (except Nicaragua) are extending ARV treatment coverage. The number of clinics should be increased, but it is also very important to improve space, means, and staffing to guarantee quality of care, promote a comprehensive care strategy, and avoid risk of the quick spread of resistance due to poor compliance.

Decentralization of care is under development in Panama and El Salvador. Those countries had the greatest increase in people under ARV treatment since 2001. In Honduras in 2003, the program supported by the Global Fund will promote an increase in number and coverage of AIDS clinics. Guatemala also plans to set up several regional clinics to complement existing care facilities in the capital city (see Table 2).

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<sup>56</sup> Report by Mr. Daniel Muralles. Clínica Luis Ángel García. ASI, November 4, 2002. Guatemala.

<sup>57</sup> Informed by Dr. Jose Roberto Trejo. San Pedro Sula. Honduras.

<sup>58</sup> Interview with Dr. Enoch Padilla. Tegucigalpa, Honduras.

<sup>59</sup> Eduardo Arathoon. "Las Investigaciones con ARV. Que Pasa Cuando Finalizan". Proceedings of the 1st Central American Conference for Access to Essential Medicines, Antigua Guatemala, June 2001.

**Table 2. Estimation of Number of People Living with HIV/AIDS in Need of ARV Treatment and Potential for Creation of New HIV Care Centers**

<b>National and regional estimates</b>	<b>Population 2001 (UNAIDS)<sup>60</sup></b>	<b>People living with HIV/AIDS (UNAIDS)</b>	<b>% adults living with HIV (15-49 years) (UNAIDS)</b>	<b>Estimated numbers in ARV treatment</b>	<b>People in need of immediate treatment<sup>61</sup></b>
Belize	321,000	2,500	2%	30	250
Costa Rica	4,112,000	11,000	0.6%	1,000	50
El Salvador	6,400,000	24,000	0.6%	650	1,500
Guatemala	11,687,000	67,000	1%	1,400	4,600
Honduras	6,575,000	57,000	1.6%	450	5,000
Nicaragua	5,208,000	5,800	0.2%	50	450
Panama	2,899,000	25,000	1.5%	1,150	200
<b>Total</b>	<b>37,202,000</b>	<b>192,300</b>	<b>1.05%</b>	<b>4,730</b>	<b>12,050</b>

<sup>60</sup> Data on population, estimates of people living with HIV/AIDS and adult prevalence have been taken from the report on the Global HIV/AIDS epidemic 2002. UNAIDS. pp 198.

<sup>61</sup> Estimates of people with criteria for ARV treatment (less than 200 CD4 or AIDS symptoms). Projection by Olaf Valverde. Calculation was based in 10% of HIV case prevalence (UNAIDS estimates) and modified according to updated seroprevalence data, and date of increase of the incidence curve of reported cases in each country. Recent epidemic increase and low seroprevalence data led to reduced case estimates. Not everyone has access to the health system, so actual demand would be smaller. Panama treatment coverage is high, and case estimates have been considered too high.

## **V. Health System Responsiveness**

### **A. Health sector reform**

Honduras, Panama, and El Salvador are involved in complex reforms of their health systems. Honduras and Panama aim at decentralization and the introduction of NGOs as primary care service providers. The InterAmerican Development Bank (IDB) supports both.

Honduras, according to its new government plan (2002–2006), intends to transfer health service management to municipalities and communities. They will start by creating a foundation to manage the Hospital of Puerto Cortes on the Caribbean coast<sup>62</sup>. In Honduras, the medical association organized several meetings to discuss reform.

In El Salvador, the social security system is expected to initiate reform that includes contracting private providers and free choice of doctors for all users. Strikes and demonstrations by health care workers against the initiative were held during the assessment visit<sup>63</sup>.

In Guatemala, social security personnel began a strike in September. Government health care workers struck again in November requesting wage increases. In Nicaragua, there was also a movement among health staff to demand better salaries. Planning for a USAID intervention must carefully consider these developments, both to avoid being involved in internal conflicts and to allow for possible delays in execution.

### **B. Concentration of specialized care**

In Central America, a regular pattern of AIDS treatment exists in every country. Only a few centers in each country can provide and follow ARV therapy protocols. There are a limited number of specialists in infectious diseases, and the clinics are overwhelmed and understaffed. The problem is more severe in Honduras where a rapid increase in available antiretroviral agents has pushed the clinic staff to the verge of collapse. Offering ARV therapy has clearly attracted patients, and every clinic has seen a steady growth in its caseload.

### **C. Difficulties in making an early diagnosis of HIV**

Two doctors reported that 70 percent of recently diagnosed HIV cases in their clinical settings already had symptoms or full-blown AIDS<sup>64</sup>. The social perception of AIDS as a disease to be hidden is one of the main reasons for late diagnosis. Neither the general population nor health professionals recognize the possibility of HIV infection and request early testing. Until now, AIDS has been considered inevitably fatal so often there are few referrals from primary health care units to specialized clinics. A few media campaigns have promoted HIV counseling; however, most of them are directed to pregnant women.

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<sup>62</sup> Meeting with Dr. Humberto Cosenza, Health Advisor for International Cooperation, Secretary of Health Honduras. October 17, 2002.

<sup>63</sup> La Prensa Grafica, October 23, 2002 and following days, El Salvador.

<sup>64</sup> Dr. Nestor Sosa of Panama and Dr. Eduardo Arathoon of Guatemala

#### **D. Constraints on HIV testing and counseling**

Considerable efforts have been made to train people in counseling throughout the region, though the quality of the training could not be assessed. In Guatemala, there is a network of counselors<sup>65</sup>; in El Salvador, health staff received extensive training, but there have been difficulties with monitoring. There is no clear direction to promote testing, and norms for VCT are still under development<sup>66</sup>. Other countries have not yet trained their health staff in VCT.

There is limited availability of simple, quick, and ready-to-use HIV tests. All countries are revising or have recently revised their national guidelines for testing. Rapid tests are being introduced; however, test results usually take at least one week to be reported, and a significant number of clients never come back to get their results<sup>67</sup>. Present HIV-testing algorithms do not always comply with WHO norms and include methods that require a sophisticated laboratory. They often rely on the third-generation enzyme linked immuno sorbent assay (ELISA) tests with a Western Blot antibody test to confirm which is very expensive and consequently often unavailable.

#### **E. Lack of a commitment to secondary and primary levels of care**

A person identified with HIV in a secondary or primary health care facility is usually referred to specialized clinics, most often in the capital city<sup>68</sup>. There is often no referral back to the primary care level even if most of the patient's needs could be met there. Perhaps because of some of these difficulties, individuals with HIV are often not referred to specialty clinics in the first place.

#### **F. Difficulties for PMTCT programs**

El Salvador (with the support of MSF) and Panama have formal PMTCT programs, and antenatal care coverage is 70 percent in both countries according to reports of their national AIDS programs. (It is 86 percent in Panama and 40 percent in El Salvador according to other sources). The social security systems in both countries have already decided to use triple ARV therapy in their PMTCT programs. Guatemala and Honduras have not yet expanded the use of HIV testing in antenatal care beyond the main maternity hospitals.

#### **G. Lack of coordination among health programs (mother and child health, tuberculosis control, sexually transmitted infections)**

The vertical organization of the Ministries of Health complicates horizontal communication among health programs. Misunderstandings are common between mother and child health programs and STI/HIV/AIDS control programs. Conflict exists among programs such as condom promotion, artificial formula for children born to HIV-positive mothers, and routine HIV testing for pregnant women.

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<sup>65</sup> PASCA trained and developed this network since 1998 in Guatemala.

<sup>66</sup> Interview with Dr. Rodrigo Siman, Head of the National AIDS Program in El Salvador. October 24, 2002.

<sup>67</sup> A study by ASI of Guatemala, based on their experience in Clinic Luis Angel Garcia, was presented at the II Congress of AIDS in Central America (CONCASIDA), Guatemala, November 2001. They could demonstrate that by reducing the time between test and communication of results, the number of people coming back to get them increased markedly.

<sup>68</sup> With the exception of San Pedro Sula in Honduras, all other specialized clinics are located in the capital cities of each Central American country.

In Guatemala, HIV testing is not included in antenatal care exams. El Salvador has plans to extend VCT beyond the 12 centers in the pilot PMTCT program. Honduras has a program with low coverage and plans to extend it with the support of USAID<sup>69</sup>. In Nicaragua, although zidovudine (AZT) is officially available for pregnant women (protocol ACTG076), only two women benefited from it in 2002.

TB control programs have loose links with AIDS control programs. There are no common treatment protocols, prophylaxis, diagnostics, or referral criteria. In Guatemala, cases of TB and HIV-positive co-infection were not reported to the national AIDS case registry during 2002. The preparation of the Global Fund proposal was a good opportunity to link both programs. Honduras has the only proposal that does not include joint activities.

STIs are normally the responsibility of the national AIDS programs. Only one STI clinic in Guatemala was visited during this assessment. It has a direct link with the AIDS clinics, but that is mainly based on personal relationships between the directors. STI control remains a low priority among AIDS issues in the national programs. Theoretically, all Central American countries have chosen to manage syndromes based on PAHO guidelines. In practice, most primary care providers are reluctant to apply it. Several countries of the region have compulsory, regular, specialized clinics for FSWs. This, however, often means that STIs are not actively screened for in general clinics, which yields an extremely low detection rate among the general population.

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<sup>69</sup> Plan for the next five years of USAID Honduras. Interview with Mr. John Rogosh and Dr. Angel Coca.



## **VI. USAID Assistance Approach**

During the early years of the HIV/AIDS pandemic, USAID focused its efforts and resources on supporting governments to:

- Develop strategic plans
- Initiate condom social marketing aimed at at-risk populations
- BCI for high-risk groups
- Develop advocacy groups
- Train health staff
- Prepare public information materials and campaigns
- Develop information systems to identify problem areas and monitor program activities

In 2001, USAID initiated its “expanded response” strategy designed to enhance the ability of countries to prevent new HIV/AIDS infections and to provide services to those who are either infected or otherwise affected by the epidemic, especially mothers, children, and youth.

Under its new strategy and in collaboration with other international donors, host governments, NGOs, and local advocacy and support groups, USAID will work toward the following international targets by 2007:

- Reduce HIV prevalence rates among 15-24-year-olds by 50 percent in high prevalence countries
- Maintain prevalence below 1 percent among 15-49-year-olds in low prevalence countries
- Ensure that at least 25 percent of HIV/AIDS-infected mothers in high prevalence countries have access to interventions to reduce HIV transmission to their infants.
- Help local institutions to provide basic care and psychosocial support to at least 25 percent of HIV-infected persons and to provide community support services to at least 25 percent of children affected by AIDS in high prevalence countries

Under this USAID strategy, Honduras is a priority for intensive focus for the next three to five years to reduce the severity and magnitude of HIV/AIDS, to keep HIV prevalence low, to reduce HIV transmission from mother to child, and to increase support services to people living with and affected by AIDS. El Salvador, Guatemala, and Nicaragua are identified as countries to receive basic support to help them move toward the 2007 targets. The Central America Regional Program will be strengthened to provide technical assistance to develop programs to focus on sub-epidemics among the most at-risk populations and to implement cross-border activities and other programs to deal with migrant populations.

The strategic objective of the Central American HIV/AIDS Program is, “The HIV/AIDS Problem in Central America Contained and Controlled.” This objective is to be achieved through three Intermediate Results (IR):

1. Continuing support for effective behavior change in high-risk groups with priority given to “hot spots” in the region
2. Improved policies implemented at the national and local levels
3. Effective delivery of comprehensive care and secondary prevention services

This assessment focuses on the current status of HIV/AIDS care, support and treatment in each of the Central American countries and provides a series of findings and recommendations for future USAID/G-CAP activities.

The USAID regional HIV/AIDS program has focused largely on activities related to Intermediate Results 1 and 2, with only limited resources devoted to Intermediate Result 3. This assessment is a first step in defining the activities that might be implemented by the regional program under Intermediate Result 3.

Donor resources for HIV/AIDS activities in Central America have concentrated on prevention of the infection, development of appropriate national policies and strategies, and development and implementation of public awareness campaigns, especially among at-risk groups, MSM, and commercial sex workers (CSWs). Until recently, donors provided scant resources for HIV care and support leaving this important element to families of PLWHA, families, friends, occasional local support groups, and ultimately the public health facilities within each country.

The focus of governmental and donor programs in Central America remains largely prevention oriented with only scattered attention and programs aimed at continuing care for PLWHA.

The regional project through PASCA has assisted in the following policy developments.

- **Honduras** designed its first national HIV/AIDS strategic plan in 1998, incorporating extensive multisectoral participation by PLWHA, and in 1999, the government passed legislation to protect the rights of PLWHA. A national commission to coordinate national HIV/AIDS policies was established the same year.
- **El Salvador** began prevention activities in 1996 and in 1999, approved a strategic plan for prevention and control of HIV/AIDS. More recently, the government passed legislation to protect the rights of PLWHA and expanded its efforts to care for them.
- **Guatemala** passed legislation declaring HIV/AIDS to be a problem of “national urgency” and protecting the human rights of PLWHA. A national STI/HIV/AIDS strategic plan for 1999–2003 includes provision for creation of a national unit within the Ministry of Public Health to provide care for PLWHA.
- **Nicaragua** established a National Program for the Prevention and Control of HIV/AIDS and Sexually Transmitted Infections in 1998 under the Ministry of Health. While largely aimed at prevention, the plan provides for the integrated management of PLWHA.
- **Panama** does not have an HIV/AIDS strategic plan, but in 2001, the President identified several HIV/AIDS priorities including the provision of physical and psychological care support services to PLWHA.

## **VII. Findings**

### **A. HIV/AIDS diagnosis and testing**

One of the main ways to limit the spread of HIV is early diagnosis accompanied by counseling. In Central America, this essential component of secondary prevention has been neglected. Other components of secondary prevention include prophylaxis and early treatment of STIs, TB, and other AIDS-related opportunistic infections (OIs). As stated above, several factors contribute to the spread of the disease, i.e., moral judgments and prejudices that keep AIDS hidden, lack of responsiveness by the health system, and stigma and discrimination against PLWHA.

The complexity of making a diagnosis is another important factor. There have been efforts to promote informed testing by training counselors in the region. Unfortunately, national protocols for HIV testing have, until recently, required complex and expensive examinations that only formal clinical laboratories can perform. Budgets and supplies needed are planned one year in advance in each center of the public health system. The growing need for AIDS testing is not reflected in the plans, and the lack of reagents delays testing in the public laboratories for long periods. Only specialized referral centers have a continuous supply.

Lack of availability has pushed some testing to the private sector where there is little ability to control the accuracy of results or the compliance with appropriate counseling and testing algorithms. Costs are high and frequently customers opt to confirm results themselves in a second laboratory. Recently in Guatemala, a network of private laboratories has organized an external quality control accreditation system<sup>70</sup>.

Honduras has a testing algorithm that begins with a third-generation ELISA test. If it is positive, there is a second blood extraction and the same test is repeated. If the person does not have AIDS symptoms, a diagnosis should be confirmed by a Western Blot test<sup>71</sup>. This test is available only in Tegucigalpa or in private laboratories. It is rarely used because it is expensive. In Honduras, health regions have decentralized budgets and management. Some of them have introduced rapid testing for initial screening (Determine, Serodia, Multispot). In the AIDS clinic in Tela, MSF uses an initial rapid test (Determine) and a second test (ELISA). For 2003, they plan to have a second rapid test, Unigold, to confirm the diagnosis<sup>72</sup>.

In the Panamanian Social Security System (IPSS), HIV diagnosis is based on the ELISA test (third and fourth generation) using two different methods in the hospital and a third ELISA test in the referral laboratory to confirm each positive case. They no longer use the Western Blot test. In the AIDS clinics, screening is done with rapid tests, especially for

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<sup>70</sup> Interview with Dr. Lucrecia Peinado, USAID, October 28, 2002, confirmed by Daniel Muralles, Clinica Luis Angel Garcia, November 4, 2002, Guatemala.

<sup>71</sup> By the end of October 2002, the National AIDS Program received a visit by Dr. Jose Maria Hermida from PAHO, Washington. One of the main purposes of the visit was to prepare a new testing algorithm including rapid testing. If accepted, this would change dramatically the availability of HIV testing in the peripheral clinics of the health system.

<sup>72</sup> Interview with Dr. Antonio Girona. Médecins Sans Frontières, October 18, 2002, Tegucigalpa, Honduras.

post-exposure prophylaxis (PEP)<sup>73</sup>. Results are normally delayed one or two weeks and confirmation requires one month. Depending on the availability of tests, results can be communicated to patients after one or two exams pending definitive confirmation<sup>74</sup>.

The National AIDS Program of Panama assessed various rapid tests and approved three to help expand coverage. Those are Dia Wiener, Combaid-RS, and Serodia. A few years ago, nurses, social workers, and psychologists in the health centers were trained in counseling, mainly to promote PMTCT. A round of training needs to be organized for new health workers. Training manuals were produced with support from the Spanish government<sup>75</sup>. Activists report problems with lack of confidentiality among health center personnel<sup>76</sup>. This could limit the willingness of people to get an early diagnosis. Since April 2002, HIV testing has been introduced formally in an antenatal consultation program at a cost of US\$7.00 for a complete set of tests<sup>77</sup>, including counseling. In case of an HIV-positive result, there is a component of active contact tracing<sup>78</sup>.

New treatment protocols for PLWHA were published this year in El Salvador<sup>79</sup>. The country proposes initial screening with rapid tests (Serodia or Determine) and then confirmation with ELISA. If both are positive, another ELISA test is requested in a different laboratory, but it may be the same method. According to the protocols, the central laboratory should confirm with the Western Blot test, but this is only recommended for asymptomatic individuals. The main problem identified is the lack of reagents for the Western Blot test and frequent delays in confirmation<sup>80</sup>. The central laboratory has three ELISA test methods. Quality control is normally done with all positive results and with 10 percent of negative ones<sup>81</sup>. In the main adult referral hospital, diagnosis is done twice with the same ELISA test with different samples. Patients have to pay US\$6.00 for testing, but social workers can waive the payment<sup>82</sup>. The social security system is able to provide test results within eight to 15 days. It reports almost 100 percent testing coverage among pregnant women<sup>83</sup>. Activist groups state that weak counseling practices, lack of confidentiality, and delays in diagnosis are barriers to access to diagnosis and treatment<sup>84</sup>. Surgeons often request HIV testing prior to elective surgery<sup>85</sup>.

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<sup>73</sup> Interview with Dr. Nestor Sosa. Infectious Diseases specialist. IPSS, October 21, 2002, Panama.

<sup>74</sup> Interview with Dr. Laura Thomas. Epidemiology. IPSS, October 21, 2002, Panama.

<sup>75</sup> Interview with Dr. Gladys Guerrero, head of the National AIDS Program, October 21, 2002, Panama.

<sup>76</sup> Interview with PROBIDSIDA, October 21, 2002, Panama.

<sup>77</sup> Tests included are hemoglobin, hematocrit, urine, glucose, VDRL, and HIV. The Social Security System also includes rubella, toxoplasmosis, and hepatitis B. Women are oriented to get all tests.

<sup>78</sup> Interview with Dept. de Atención a la Población. October 21, 2002. Panamá.

<sup>79</sup> Protocolos de Atención de Personas Infeccionadas por VIH, Programa Nacional de Prevención y Control de ITS/VIH/SIDA, Abril 2002, El Salvador.

<sup>80</sup> Interview with Dr. Rodrigo Siman, National AIDS Program, October 24, 2002, El Salvador.

<sup>81</sup> Interview with Lic. Sonia Velásquez. Resp. Unidad SIDA. Laboratorio central Max Bloch. October 24, 2002, El Salvador.

<sup>82</sup> Interview with Dr. Rolando Zedillos, Infectologist, Hospital Rosales, October 25, 2002, El Salvador.

<sup>83</sup> Interview with Dr. Jose Viana, Infectious Diseases Specialist, Social Security, October 25, 2002, El Salvador.

<sup>84</sup> Interview with Odir Miranda and Otto Ramirez, ATLCATL, October 24, 2002, El Salvador.

<sup>85</sup> Formally recommended by the Protocolos de Atención de Personas Infeccionadas por VIH, Programa Nacional de Prevención y Control de ITS/VIH/SIDA, El Salvador, Abril 2002. pp. 132.

In El Salvador, health centers manage their own budgets. Prior to June, centers had the opportunity to supplement their incomes with small co-payments from patients. These payments were stopped, and at the time of the visit, many centers had problems with an inadequate supply of HIV tests. The maternity hospital had only 19 percent of pregnant women tested. In the hospital, two ELISA tests are performed, and in the peripheral units, women are screened with Determine. HIV testing is offered based upon high-risk criteria<sup>86</sup>. ARV therapy for HIV-positive women follows two treatment protocols (AZT and/or Nevirapine) according to the gestational age at the time of diagnosis. After delivery, sterilization is promoted<sup>87</sup>.

In Guatemala, national ARV treatment protocols recommend two different ELISA tests, two rapid tests, or a combination of both, according to the level of the testing place or laboratory. In asymptomatic, HIV-positive persons, it is recommended that the third test should be a Western Blot<sup>88</sup>. The first screening test is normally Determine, but other rapid tests like Hexagon are also being used<sup>89</sup>. The supply system for tests is organized through the health areas, but the national AIDS program complements it with additional supplies. The laboratory at the NGO ASI was finishing a study comparing four rapid HIV tests<sup>90</sup>. In TB Hospital San Vicente, only 35 percent of patients agreed to be tested. Of those tested, one-third were HIV-positive in 2002 (12 percent of all)<sup>91</sup>. Nicaragua does not have an effective public service for testing and diagnosis. Some private providers undertake testing and counseling in Managua; MSF supported a project undertaking VCT in Bluefields but the support ended in December 2002.

In Central America, early VCT should be promoted as an important tool to control the spread of HIV. This must be accompanied by increased capacity of HIV diagnosis by peripheral health units based on rapid tests. Central laboratories and those with high testing turnover should base their testing strategy on more complex ELISA testing. A system including referral for confirmation and quality control should be improved to reduce the time span between testing and communication of results. Counseling should be more proactive to include most persons at risk (TB patients, pregnant women, sex workers, MSM, and, in general, all people requesting testing).

## **B. Building Blocks strategy**

The Building Blocks framework for HIV/AIDS comprehensive care has been chosen as the model for organizing HIV care in the Central American countries. This strategy was developed in two meetings: one in Cancun, Mexico in November 1998 and one in Antigua,

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<sup>86</sup> High risks in pregnant women are: having tattoos, women without antenatal consultation, having an STI on couple known to be HIV-positive.

<sup>87</sup> Meeting with the Maternity Hospital Team. October 25, 2002. El Salvador.

<sup>88</sup> Protocolo Nacional para el Tratamiento Antirretroviral del VIH/SIDA. Comisión de Acceso a Tratamiento. Programa nacional de SIDA. Ministerio de Salud. Junio 2002. pp.36. Guatemala.

<sup>89</sup> Informed by Dory Lucas, Director of the National AIDS Program, October 29, 2002, and Dr. Zonia Pinzon, Referral Center for STI treatment, October 31, 2002, Guatemala.

<sup>90</sup> Those tests were: Oraquick, Instant Screen, Effora, and Determine. They were compared with an ELISA. Preliminary results were very positive. Informed by Annelise de Salazar and Daniel Muralles. ASI, November 4, 2002, Guatemala.

<sup>91</sup> Interview with Dr. Marco Perez and Dr. Judith Garcia. Hospital Antituberculoso San Vicente, October 30, 2002, Guatemala.

Guatemala in May 1999. The final version of the document was published in June 2000 by PAHO and WHO in collaboration with UNAIDS and the International Association of Physicians in AIDS Care (IAPAC)<sup>92</sup>. Every country visited expressed the political will to incorporate the building blocks model, but it has not yet been implemented widely.

Comprehensive care consists of four interrelated elements:

1. Clinical management, including early diagnosis, rational treatment and follow-up
2. Nursing care, including primary prevention, promotion of hygiene practices and nutrition, family planning services, promotion of universal precautions, home care, and education to care providers
3. Counseling, psychosocial support, stress and anxiety reduction, risk reduction, including condom promotion and positive living
4. Social support with information, referral to peer support, welfare services, spiritual support, and legal advice

Clinical and nursing care is the responsibility of the health team while sources of support include family members and caregivers, members of the community at large, and the health team. Clinical interventions occur throughout different levels of the health system, and care should address the continuum of needs of PLWHA.

The Building Blocks strategy has been specifically incorporated into the national ARV treatment protocols in Guatemala; their inclusion is valid for the entire region<sup>93</sup>. Each country is unique in its ability to offer comprehensive HIV care. Limited resources may restrict a health system's ability to offer the full range of services everywhere; however, coverage may be increased over time. Decentralization and expansion of specialized services are needed to achieve full coverage of comprehensive care and support.

The results have not been formally assessed, but most opinions of PLWHA benefiting from Building Blocks programs were clearly favorable. In contrast, health professionals complained about the lack of means to perform better and provide more comprehensive services. Many of the Building Blocks programs required the additional services of volunteers.

### **C. Clinical settings**

The team assessed several tertiary care units in each country visited. Detailed information on each unit can be found in Annex 3. The clinical care of PLWHA and the management of ARV therapy are concentrated at this level of the public health and social security systems. Some private clinics, mainly nonprofit, have developed ARV treatment programs. In most countries, antiretroviral therapy and the treatment of OIs are offered by infectious disease specialists but only in the major urban centers (see Table 3).

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<sup>92</sup> Building Blocks: Proceedings of the Consultations on Standards of care for Persons Living with HIV/AIDS in the Americas. PAHO, WHO, UNAIDS, IAPAC, June 2000.

<sup>93</sup> Protocolo Nacional para el tratamiento antirretroviral del VIH/SIDA. Comisión de Acceso a Tratamiento Programa Nacional de SIDA, junio 2002, Guatemala.

**Table 3. Clinics Treating PLWHA Using Antiretroviral Drugs in Central America**

Data as of November 2002	CAPITAL CITIES			OTHER CITIES
	MOH	Social Security	Private organizations	Public and private
HONDURAS	Instituto Nacional del Torax		Solidaridad y Vida	Hospital Mario Catarino Rivas, (San Pedro Sula)
	Hospital Escuela			IHSS (San Pedro Sula)
				Juntos por la Vida (San Pedro Sula)
				Clinica de MSF (Tela)
PANAMA	Hospital Santo Tomás	IPSS		Hospital de Colón
	Hospital del Niño			
EL SALVADOR	Hospital Rosales	ISSS		
	Hospital Bloom			
	Hospital de Maternidad			
	Hospital Zacamil			
GUATEMALA	Hospital Roosevelt	IGSS	Clinica Luis Angel Garcia (ASI, H. San Juan de Dios)	Proyecto VIDA de Coatepeque
			Clinica Yaloc (MSF)	
			Clinica de Gente Nueva	
NICARAGUA	Hospital Roberto Calderon			
	Hospital Manuel de Jesus Rivera			

Most tertiary clinics have multidisciplinary teams though they are often insufficiently staffed to face constantly growing demand especially since ARV became available. Among other difficulties is the lack of additional physical space to provide privacy for individual counseling. Basic laboratory testing is usually available, but specific tests such as CD4 count and viral load are normally available only in national referral laboratories. Drug supply differs in each country. Nicaragua is the worst with a national crisis in general availability of essential drugs. Honduras also has limited supplies. Guatemala and El Salvador have limits of supply for the most expensive drugs, whereas Panama is better off.

Social security systems, with the exception of those in Nicaragua and Honduras, have better resources than the Ministries of Health. Panama and El Salvador have a regular supply and a wide variety of ARV drugs. The Guatemalan system has offered ARV for several years but currently faces temporary shortages and a limited number of drugs. Honduras recently began offering treatment; however, they have purchased only three drugs (AZT, 3TC, and Efavirenz), which does not allow for flexibility in the event of side effects or resistance. The staffs at these centers are motivated and willing to improve the quality and quantity of services, but they will soon reach their full capacity.

The primary and secondary levels of health care have little or nothing to do with the care and treatment of PLWHA. Once a person is diagnosed as HIV-positive or presents AIDS symptoms, he or she is immediately transferred to the infectious disease unit or to an AIDS clinic for further follow-up for OI treatment or for ARV therapy. Peripheral health staffs are often not clinically trained in AIDS, and AIDS cases remain unrecognized and undiagnosed. There is still an exaggerated fear of nosocomial infection. The concept that AIDS is a disease is widespread. VCT is limited to some peripheral units and the tertiary centers. Late diagnosis is the norm.

Programs for PMTCT have been developed in the social security systems in Panama and El Salvador. Honduras, Guatemala, and Nicaragua have formal prevention programs, but the coverage is very low and mainly among women at tertiary care centers or women actively seeking diagnosis and treatment.

Post exposure prophylaxis (PEP) is centralized in all countries. Lack of training on universal precautions leads to unnecessary risks and to patient management decisions based on their HIV status, especially among surgeons.

Tertiary clinics offer comprehensive care but with certain important limitations. Promotion and distribution of condoms and other family planning services are frequently absent. The concept of a “network of services” is often in name only and it is unidirectional (from periphery to the central, more specialized, level). There is also a “vertical” concept of care (specialized health staff directs actions). International cooperation in El Salvador has financed the creation of support groups within the clinics<sup>94</sup>, resulting in PLWHA depending on health staff to organize them. In countries with stronger health systems, like Panama and Costa Rica, the civil society movement is weak.

Guatemala and Honduras initially faced weak governmental responses to the epidemic; these countries thus developed a strong community network that led to private, nonprofit AIDS treatment clinics. In Nicaragua, civil society also took the lead. In fact, across the region, social security systems tend to work in isolation from the Ministries of Health, with the exception of Panama where common treatment units exist.

Direct involvement of NGOs and support groups varies from country to country. In San Pedro Sula, Honduras, Juntos por la Vida is involved with AIDS clinics at the Catarino Rivas Hospital. They provide support in counseling and adherence to treatment at home for those on ARV therapy. In the same city, the support group Puertas Abiertas y Casa Aurora offers OI and ARV drugs to members. In Tegucigalpa, the Asociación Solidaridad y Vida, led by Dr. Enoc Padilla, has a clinic for OI and ARV therapy. They try also to integrate other components of HIV/AIDS comprehensive care including links with hospices and orphanages.

In El Salvador, an NGO called FUNDASIDA works independently of the Ministry of Health and the ISSS by providing support to PLWHA for secondary prevention and adherence to ARV therapy. In Panama, PROBIDSIDA provides assistance to members for adherence, but they concentrate their efforts on defending human rights including improved and long-term access to ARV therapy.

In Guatemala, Gente Positiva works closely with the Roosevelt Hospital clinic and complements comprehensive care by providing psychological support and autonomous organization of self-help groups on their own premises. Other NGOs work with the Luis Angel Garcia clinic located in the San Juan de Dios Hospital, but they also work independently providing direct clinical care (including ARV for 27 persons, financed by the Ministry of Health) and dental treatment. They have rooms to receive PLWHA who come

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<sup>94</sup> Memoria de Labores 2001. Programa Nacional de SIDA, El Salvador.

for treatment from rural areas. APAES manages a drug bank providing medicines for OIs and some ARV. The Fundación Marco Antonio is a center for HIV/AIDS care and treatment. The center admits inpatients for daycare, for post-hospitalization care, or in the terminal phase of the disease.

Treatment has often been designed to offer therapy to children first and then to pregnant women and/or the children's parents. Members of the gay community who are most at risk<sup>95</sup> perceive this as discriminatory. Other high-risk groups, such as FSWs, have different problems with access because they tend to work in cities or even countries other than their own. Often, once they are diagnosed with HIV, they disappear<sup>96</sup>.

Every country has plans to decentralize and to increase coverage and treatment. Much of this effort is based on the expected approval of the proposals submitted to the Global Fund. High drug costs initially blocked political will to buy ARVs at all; however, once the decision was made to start providing them, costs still limited the amounts available. In the first half of 2002, generic producers started registering lower priced ARV drugs in Central America; however, some specialists remain skeptical about prescribing them because of bad previous experiences with other generic drugs. Quality control has improved, and in Guatemala, the government selected generic ARVs in their November 2002 bid for 160 new ARV treatments. Other countries are still reluctant to buy generics and base their cost-reduction strategy on direct negotiations with the proprietary pharmaceutical industry<sup>97</sup>.

In Central America, it is feasible to increase coverage of ARV treatment, but these risks need to be considered:

- The need to increase quickly the number of PLWHA on ARV treatment decreases quality, as is the case in Honduras.
- There is low priority given to managerial aspects. Registry systems are poor. Databases are heterogeneous and difficult to analyze.
- The lack of human resources continues to put a strain on efforts to increase concurrence with treatment. PLWHA have a role in reinforcing concurrence as has been seen in Costa Rica with the project for peer support in Hospital Mexico.
- Yearly planning for health services must predict needs in advance. It is difficult to estimate a growing demand. Supplies are often exhausted before the end of the budgetary period.

The epidemiological surveillance systems sometimes neglect information coming from health clinics. This information, if captured, may be very useful for planning service needs<sup>98</sup>. It provides vital data to understand the profile of OIs and to assess needs for hospitalization, specific drugs, and laboratory tests.

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<sup>95</sup> Interview with Comunidad Gay Sanpedrana, October 15 2002, San Pedro Sula, Honduras. Ratified by Dr. Ruben Mayorga Director of OASIS, October 30 2002, Guatemala.

<sup>96</sup> Interview with Dr. Zonia Pinzon, Head of the STI treatment center of Guatemala City. October 30, 2002,

<sup>97</sup> Report on the Campaign for Access to Essential Medicines for Central America. Olaf Valverde. July 2002.

<sup>98</sup> VIH y SIDA en España. Situación Epidemiológica 2001. Ministerio de Sanidad y Consumo. Secretaria del Plan Nacional sobre el SIDA. 2002.

## D. Training

### *Primary training of health workers*<sup>99</sup>

Pre-service training curricula refers to the curricula for the primary training of health workers in universities, nursing schools, and other health schools that make up part of the health profession's multidisciplinary team. Medical and nursing faculties at national universities in Honduras, Panama, El Salvador, Guatemala, and Nicaragua were visited. People interviewed agreed on the need to review and update curricula on HIV/AIDS for health professionals because it does not focus specifically on comprehensive care and treatment. In medical faculties, HIV/AIDS issues are included in different disciplines such as microbiology, virology, pharmacology, and infectious diseases. Medical faculties in Honduras, El Salvador, and Guatemala are currently reviewing the medical curriculum.

The following regional networks should be considered to review, update, upgrade, and validate the curricula for the whole region:

- Consejo Superior Universitario Centroamericano (CSUCA), now coordinated from Guatemala<sup>100</sup>
- Asociación Centroamericana de Facultades y Escuelas de Medicina (ACAFEM)<sup>101</sup>. (The president is Dr. Ricardo Méndez Flamenco, Dean of the Faculty of Medicine of the National University of El Salvador)
- Asociación Latinoamericana de Escuelas y Facultades de Enfermería<sup>102</sup>. (The Vice-president is Lic. Elena de la Motte, Dean of the Faculty of Nursing of the University of Panama)
- Asociación de Universidades Privadas de Centroamérica (AUPRIC)<sup>103</sup>

Improving primary training curricula is a clear need. USAID could easily help at the regional level by facilitating the following while the responsibility for implementation would remain under local universities and regional entities:

- Identification of minimum requirements for HIV/AIDS comprehensive care and treatment content, burden time, didactic material, and evaluation methods that curricula must have to be accepted and validated
- Training, updating, technical exchanges, and horizontal collaboration among faculties and universities
- Supplying university libraries with pertinent bibliographies, journals, or other kinds of scientific information related to HIV/AIDS
- Sponsoring participation of universities at international conferences and training related to HIV/AIDS (e.g., CONCASIDA)
- Presenting this initiative as a case study in the region

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<sup>99</sup> Detailed in-country information can be seen in Annex 5.

<sup>100</sup> Source: Telephone interview with Dr. Norma Martínez de Reyes, Chief of 4<sup>th</sup> University Reform Office.

<sup>101</sup> Source: Interview with Dr. Ricardo Méndez Flamenco, Dean of the Faculty of Medicine, University of El Salvador.

<sup>102</sup> Source: Interview with Lic. Elena de la Motta, Dean of the Faculty of Nursing, University of Panama.

<sup>103</sup> Source: Interview with Dr. Ricardo Méndez Flamenco, Dean of the Faculty of Medicine, University of El Salvador.

### *In-service training*<sup>104</sup>

Possibilities for postgraduate and in-service training were explored at universities and at health facilities, which provide HIV/AIDS care and treatment. All countries showed local ability and expertise for in-service training, but a detailed in-service curriculum for health staff at AIDS clinics does not exist. An in-service training program should be conceived in the context of the Building Blocks strategy to develop HIV/AIDS comprehensive care and treatment. Participants should be trained in different settings to be able to understand all aspects of comprehensive care.

It is essential to consider that early diagnosis and treatment of TB and STIs are basic components of prevention to be included in the concept of comprehensive HIV/AIDS care. Hospital del Torax in Honduras and Hospital de San Vicente in Guatemala are examples of places that could be used for short-term training. For STIs, specialized units in different countries exist, such as the UMIETS in Honduras or the referral center for STIs in Guatemala City. Cervical cancer prevention among HIV-positive women is also an important secondary prevention practice. There is a specific medical practice in Guatemala<sup>105</sup> where training can be easily organized as it has already been planned by the USAID mission bilateral program. STI treatment centers in other countries were not visited.

For postgraduate training, earning a diploma in HIV/AIDS comprehensive care and treatment was proposed to interviewees. The initiative was well accepted by the medical and nursing faculties and considered with interest by Ministry of Health representatives. Specialists welcomed the initiative with the exception of the Guatemala Infectious Disease Specialists Association where concerns were raised about a “false” sense of specialty. The universities of Panama, El Salvador, and Guatemala appeared to be the most advanced in terms of organizing such training. Another consideration is postgraduate training out of the region in Mexico or the United States.

These points were considered essential for the success of a training program:

- No training activity is successful without an appropriate follow-up of trainees once back in service.
- Specific needs of already working professionals must be considered, as prolonged international training could be difficult for them.
- Careful selection criteria must be set up before launching a training activity to include those who would be active afterwards in the field.

The following are different possible scenarios for a diploma course.

- Each country organizes and implements the course in close coordination with medical and nursing faculties, post-qualification units of selected universities, and health facilities that provide HIV/AIDS care and treatment.
- A regional diploma course could be organized. The University of Panama might be an appropriate location. El Salvador also has several well-organized clinical settings (Rosales for adults, Maternity for PMTCT, and Bloom for children).

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<sup>104</sup> More detailed in-country information can be seen in the Annex 6.

<sup>105</sup> Interview with Dr. Zonia Pinzon. Director of Referral Center for STI of Guatemala City.

- Scholarships could be offered to selected health staff for training in different diploma courses on HIV/AIDS. A diploma in HIV/AIDS could be offered at the Instituto de Salud Publica of Cuernavaca in Mexico and a Clinical Diploma in HIV/AIDS could be offered in Panama. Training capacity in Costa Rica, Brazil, the Dominican Republic, and Colombia should be explored.
- Distance training (GALEN) based on curricula developed by IAPAC could be easily organized to help increase the number of trained people<sup>106</sup>.

In conclusion, in all countries, there is little formal in-service training for health professionals in HIV/AIDS comprehensive care and treatment. Guatemala, El Salvador, and Honduras intend to expand ARV therapy and are in great need of trained HIV/AIDS health staff. Honduras is in urgent need as they plan to expand ARV therapy to 800 people, and the AIDS clinics are already saturated. It would be useful to establish an in-service training program based on the Building Blocks strategy to reinforce the secondary and primary levels of the health systems.

### **E. People living with HIV/AIDS<sup>107</sup>**

PLWHA NGOs and those who support PLWHA in all of the countries visited without exception said PLWHA suffer from discrimination by health workers. It ranks from ignoring and neglecting them up to totally isolating them. One of the NGOs said in a hospital in Guatemala, food for PLWHA in isolation wards is left at the door of the room and is served on disposable crockery. The attitude of surgeons and gynecologists seems to be the most negative. These professionals routinely request an HIV test prior to surgical operations, including Cesarean sections. In some cases, when someone living with HIV/AIDS needs an operation, doctors repeatedly postpone it.

PLWHA complained they are always relegated to outpatient clinics and that they have a difficult time finding a dentist who will treat them. For emergency services, PLWHA are the last people to be attended to because of HIV/ AIDS. PLWHA suggested that health workers should change their attitudes by improving HIV/AIDS knowledge and training, but they also felt the need to provide PLWHA with legal assistance to be able to defend their rights.

PLWHA mentioned violations of human rights and national legislation on HIV/AIDS at places of employment in all of the countries visited. Certain employers routinely require HIV testing for their workers or for people requesting employment. If someone is HIV-positive, he or she is fired or not hired. In this way, PLWHA are excluded from the workforce adding a heavy burden to their already precarious living conditions. During interviews, PLWHA demanded the opportunity to work and the provision of legal support to defend their right to work to improve their self-esteem and living conditions.

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<sup>106</sup> GALEN is an intensive 15-module course of instruction in basic and advanced HIV medicine. The curriculum is based upon a consultative process involving a 22-member GALEN Curriculum Committee, the World Health Organization (WHO), and representatives of the health professional, and patient communities. [Visit the IAPAC Web site— [www.iapac.org](http://www.iapac.org) —for detailed information as well as training and/or examination schedules.]

<sup>107</sup> More detailed in-country information can be seen in Annex 7, and a directory of the organizations in Annex 8.

To provide food security, some groups suggested training and opportunities to find jobs. The use of micro-credit mechanisms to establish micro-enterprises was also suggested. Other groups preferred the idea of providing nutritional supplements to PLWHA to improve health and guarantee better adherence to ARV therapy.

In conclusion, PLWHA still face stigma and discrimination. Even though there is legislation to protect their rights, it is not respected. The majority of PLWHA live in poor conditions with few opportunities for finding jobs. Nutritional supplements are desperately needed for PLWHA who are poor, malnourished, or in an advanced stage of the disease. The team recommends legal assistance to PLWHA to defend their rights, support for PLWHA through micro-credit or the creation of micro-enterprises to improve family incomes, and the provision of nutritional supplements according to general health status and socioeconomic situation.



## VIII. Issues

Three major issues have been identified to assure efficient, comprehensive care for PLWHA in Central America:

- Improve response to comprehensive care needs
- Provide flexible, effective training to health professionals in various disciplines
- Link and support NGO and groups of PLWHA to integrate PLWHA back into society

### A. Improve response to comprehensive care needs

There is an urgent need to expand and to integrate activities to provide comprehensive care for PLWHA. Knowledge and best practices must be shared among Central American countries to find and apply the most efficient methods to improve survival and quality of life of PLWHA. VCT must be widely extended to promote early case detection and care and to provide individually oriented education to prevent the further spread of HIV/AIDS.

USAID/G-CAP could promote one or two pilot projects in each country to explore the best ways to expand coverage and increase comprehensive care and support of PLWHA. The assessment team identified possible project sites in each country, but circumstances can change quickly and sites should be reassessed before starting an intervention.

Honduras needs earlier and more extensive action. ARV treatment began later in Honduras, but a large increase in cases is expected due to the approval of the Global Fund proposal. Funding should begin in early 2003, but the numbers of qualified professionals are too few to cope with treatment needs and to train new professionals adequately.

In **Honduras** two possible settings for the creation of a pilot network of services were identified:

1. The existing clinic in Hospital Mario Catarino Rivas of San Pedro Sula, where activities could be extended to the following:
  - Health Center of Miguel Paz Barahona in the same city, where a motivated team has been identified
  - Hospital of La Ceiba, which is proposed for a new AIDS clinic
  - Hospital of Tela, where MSF is supporting a cohort of PLWHA with ARV therapy in a clinic outside the hospital
2. The Hospital del Torax in Tegucigalpa where the head of the clinic has proposed a training program. The network could include the following:
  - Health Center of Alonso Suazo, one of the biggest centers in the capital city
  - Health Center of Las Crucitas which is committed and well organized and also in the capital city
  - The Hospital of Comayagua, which has a nearby department with high HIV prevalence.

In **Guatemala**, the team proposes two settings:

1. The Roosevelt Hospital as the referral center. The project could concentrate on the following hospitals:
  - The Hospital of Coatepeque where MSF is supporting a private, not-for-profit ARV clinic outside the Hospital (Proyecto VIDA);
  - The Hospital of Malacatan in San Marcos on the border with Mexico;
  - The Hospital of Mazatenango that has a high prevalence department. This hospital is well organized and has a motivated staff.
2. The San Juan de Dios Hospital as the referral center. (Clínica Luis Ángel García, situated in the Hospital grounds, is privately managed.) The project could concentrate on these hospitals:
  - Hospital of Puerto Barrios, a priority area on the Caribbean coast. MSF is considering starting an ARV treatment project in this area by the second half of 2003 but has not decided on the exact location.
  - Health Center of Morales, an area with high prevalence and a mobile population
  - Hospital of Poptun, the closest district within Peten Department

In **El Salvador** one network could be organized in Rosales Hospital, in close coordination with the Maternity Hospital for pregnant women and Bloom Hospital for children, linked with:

- Concepcion Health Center in San Salvador;
- Hospital of Sonsonate;
- Hospital of Santa Ana.

In **Panama** the choice is to have Hospital del Seguro Social or Santo Tomas and Hospital del Niño as referral centers linked with:

- Hospital Manuel Amador Guerrero of Colon, where there is high prevalence and the Ministry of Health and social security system are integrated
- Two polyclinics and the health centers of Colon Department

In **Nicaragua**, support ought to be more centralized in Hospital Roberto Calderon Gutierrez and Manuel de Jesus Rivera Children's Hospital because treatment is less organized. Links would be with the following:

- Managua health centers to be identified
- Hospital of Chinandega
- Teaching Hospital of Leon

USAID/G-CAP should work to organize the formal links among the selected institutions including referrals and counter-referrals. Centers of the network should actively promote greater personal awareness of serostatus through promotion and provision of quality, confidential, VCT services, and should guarantee minimum standards of quality comprehensive care. There should also be an effort to include community organizations and groups of PLWHA, in the selected areas.

It will be important to integrate USAID/G-CAP actions with other actors to increase impact. Global Fund proposals include actions for decentralization and network development. MSF can be an important partner in Honduras and Guatemala as they are already supporting peripheral clinics (including ARV drug supply) and have developed useful monitoring and training instruments. USAID mission bilateral programs could have an important input. Other donors (such as the IDB) are supporting reform towards decentralization of the health system. Parallel prevention or education programs in geographical areas selected for intervention must also be considered.

## **B. Provide training to health professionals in various disciplines in a flexible and effective way**

Primary training is biologically oriented and does not include complex, interdisciplinary aspects of comprehensive care. Prevention, the sexual life of PLWHA, and use of condoms are subjects avoided even by the best-trained specialists. There are not enough well trained professionals to cope with the increasing treatment needs. Many short, in-service training workshops exist, but there is no national training program, and there is a lack of appropriate follow-up.

An important strength is the existence of formal networks and the willingness of experienced professionals to improve the training situation. There is an urgent need for political and budgetary commitments to increasing human resources dedicated to HIV/AIDS care and support in the public health systems. Local experts should be able to dedicate part of their time to training new staff.

There is a clear role for USAID/G-CAP to promote regional cooperation for training activities. Primary training curricula should be standardized regionally and adapted to include all aspects of comprehensive care using the networks of schools and universities. In-service training must avoid short training workshops without follow-up. A flexible training program has to be developed using regional strengths and promoting international exchange. This program could range from formal three-month diploma courses to distance learning. Stable follow-up must be organized and based on experts' regular visits to the peripheral centers.

## **C. Link and support NGO and groups of PLWHA to integrate PLWHA back into society, overcoming stigma and discrimination**

The first demand raised by PLWHA is always access to ARV treatment. Once ARV treatment is obtained, other problems emerge. Stigma and discrimination increase PLWHA suffering and complicate their lives once AIDS progression is controlled by ARV therapy. It may impede adequate adherence to treatment and accelerate the appearance of resistant strains of HIV. Confidentiality is very important to reduce discrimination.

PLWHA said unanimously that their main need, once ARV treatment is begun, is the ability to live productive lives. USAID/G-CAP and bilateral missions can make significant efforts to fight discrimination and defend human rights of PLWHA, including training and awareness activities addressed to PLWHA, medical and health staff, and other public servants involved in resolving the needs of PLWHA.

USAID/G-CAP can promote the following three new actions to meet the needs of PLWHA. These actions should be channeled through local NGOs and support groups. Training, financial support, and monitoring of these groups is essential to increase effectiveness.

1. Access to work should be promoted by different means. Long-term actions reinforcing confidentiality should be directed to fight discrimination by employers who request HIV testing of employees. Finding jobs for PLWHA can be promoted by including them in an active search or in micro-credit programs.
2. Training for the creation of micro-enterprises or for increasing the qualifications and skills for finding jobs—including learning to read and write—could improve chances for self-support.
3. Food support should be provided for those in precarious situations along with nutritional education in general to help PLWHA adapt to ARV treatment.

Most actions can be channeled through international cooperative programs (food support or micro-credit). Training for PLWHA can also use existing national structures. In Guatemala, the Instituto de Nutricion de Centroamerica y Panama (INCAP) provides professional training courses. In most countries, there are free programs to learn to read and write. Legal advice can be included in wider programs to defend human rights. Groups of PLWHA or supporting NGOs, if adequately funded, could also directly provide some of these activities such as training or promoting human rights.

## **IX. Conclusions**

### **A. Comprehensive care needs**

- HIV diagnosis is too late, too complex, and coverage is low.
- ARV therapy is increasingly available in the public health systems (except in Nicaragua).
- The AIDS care system has good quality standards but often-inadequate resources, and is concentrated at the tertiary/specialized level, which is overburdened and understaffed.
- Health centers and peripheral hospitals are seldom involved in care and support of PLWHA.
- Comprehensive care is not integrated; it is composed of many unlinked initiatives. There are important exceptions that could be utilized as models (examples: Roosevelt Hospital in Guatemala or Solidaridad y Vida in Tegucigalpa, Honduras).
- In each country, there is limited integration of related activities among health programs (mother and child health, STIs, HIV/AIDS, TB) and the management level of health systems.
- Officials and professionals seldom communicate among countries on programmatic issues resulting in duplication of guidelines, norms, and protocols.
- There is political interest in the region for improving care and support for PLWHA, but practical application is slow.

### **B. Training needs**

- There are few well-trained and experienced professionals in each country.
- Primary training in AIDS is biologically oriented and, especially in the medical faculties, does not consider comprehensive care.
- Formal in-service training is absent, except in Panama.
- Short-term training activities in different subjects linked with comprehensive care exist but with almost no follow-up by training staff.
- Several universities in the region and neighboring countries offer or are able to develop postgraduate courses in HIV/AIDS.
- There are links among trained professionals and U.S. hospitals and universities.

### **C. Social needs of PLWHA**

- Basic needs of PLWHA remain unmet, especially finding jobs or food for those in severe poverty. There are frequent reports of discrimination.
- PLWHA groups are effective at influencing policy. However many PLWHA groups are dependent on health structures or support organizations, and most PLWHA are not organized.
- There are good linkages among NGOs and PLWHA groups. PASCA has played an important role in creating and supporting this network.
- Most supporting organizations have difficulties covering operational expenses.



## **X. Recommendations**

- USAID/G-CAP should seize the opportunity to play a crucial role in linking the actors to develop a comprehensive care and support program in each Central American country.
- USAID/G-CAP should explore, in collaboration with Ministries of Health, bilateral missions, and other donors or actors, the best way to provide comprehensive care for PLWHA in controlled settings, promoting the PAHO Building Blocks strategy. This should be accompanied by a detailed follow-up and thorough evaluation, including possibilities for scaling-up.
- USAID/G-CAP should support efforts to decentralize quality care of HIV/AIDS including improving coverage of ARV treatment. This may involve establishing, organizing, and/or coordinating in-service and primary training for health professionals adapted to the different needs and tasks of the members of care and support teams.
- USAID/G-CAP should reinforce and empower PLWHA groups and support organizations to improve treatment follow-up, access to work, and food supplies for those PLWHA most in need, and it should defend their human rights.
- USAID/G-CAP should encourage national governments to provide adequate staff, means, and infrastructure to improve quality AIDS care.



## **Annexes**



**Annex 1:**  
**Selected Epidemiological Data on Central America**  
*(Extracted from the UNAIDS Report of June 2002)*

CENTRAL AMERICA			Estimated number of PLWHA at the end of 2001		Population 2001 (in thousands)		Range of uncertainty around estimates		HIV prevalence (%), in selected populations			
Country	Adults and children	Adults (15-49) rate %	Total	Adults (15-49)	Adults and children living with HIV/AIDS at the end of 2001		Pregnant women in urban settings		Female sex workers			
					Low estimate	High estimate	Year	Median	Year	Median		
Belize	2,500	2	321	119	2,300	3,400	1995	2.3	...	...		
Costa Rica	11,000	0.6	4,112	2,204	7,200	15,000	1997	0.3	1995	0.9		
El Salvador	24,000	0.6	6,400	3,289	16,000	32,000	1997	0.2	1993	1.1		
Guatemala	67,000	1	11,687	5,459	44,000	91,000	1998	0.9	1998	4.7		
Honduras	57,000	1.6	6,575	3,214	46,000	68,000	1998	2.9	1999	7.7		
Nicaragua	5,800	0.2	5,208	2,539	3,800	7,800	...	...	1990	1.6		
Panama	25,000	1.5	2,899	1,549	18,000	33,000	1994	0.3	...	...		



## Annex 2:

### People interviewed (by county)

	<u>Honduras</u>	<u>Puesto</u>	<u>Organización</u>	<u>Teléfono (504)</u>	<u>Correo Electrónico</u>	<u>Dirección</u>
	<b>San Pedro Sula</b>					
1	Oscar Carrion Raul Coto Jeffry Orellana Elkin Suarez		Comunidad Gay Sanpedrana	553-4362		2a. calle, 8 y 9 Ave., # 67
2	Ma. Isabel Guzman Dionel Guzman Jorge Alberto Ortega Xiomara Hernandez Reyna Figueroa Aracely Martinez Otras 4 personas	Puerta Abierta Red de Hombres VIH+ Esperanza de Vida Siempre Unidos Juntos por la Vida Red de Mujeres VIH+	ASONAPVSI DAH	556-9393 554-4988 997-2942	<a href="mailto:asonapvsidah@hotmail.com">asonapvsidah@hotmail.com</a>	Col. Altamira, 23 calle, 14 y 19 ave. No. 1404
3	Rosa Gonzalez Allan Dunaway		Fundación LLAVES (Llanto, valor y esfuerzo)	554-4998 (FunLI) cel.: 997-7800(AD) 557-4646	<a href="mailto:fundacionllaves@yahoo.com">fundacionllaves@yahoo.com</a>	Of. De CARE tel.(556-9653), Barrio Las Palmas, 20 y 21 calle 4a. Av. Frente al Registro de la Propiedad
4	Xiomara Hernández Rufino Campos Cristina Alvarez Nohe Hernandez Karen Vazquez Hernan Hernandez Elisabeth Padilla Juan Jose		Ministerio Siempre Unidos	(504)558-0423		Barrio Cabañas, 13 calle, 14 ave., SE; casa de esquina color verde/blanco
5	Dr. Manuel Solis	Programa VIH/SIDA	Project HOPE	550-4029/566-2636 SPS 232-3404/2667 Tegu	<a href="mailto:hopevihsida@123.hn">hopevihsida@123.hn</a>	Edif. Bougamvilia, Local #3, Santa Ana. Blvd. Escuela Internacional, frente a entrada a emergencia del Hosp. Mario Catarino Rivas
6	Doris Regan Oscar Valderrama Ana María Pineda	Colaboradora, coordinador promotora social.	Casa Aurora	(504)552-3193		Col. Aurora 7, Calle B, 14 y 15 Ave., S.E., zona 9, #1494; ultima calle de Col. Aurora, contigua a campo de Timbal
	<b>Honduras</b>	<b>Puesto</b>	<b>Organización</b>	<b>Teléfono (504)</b>	<b>Correo Electrónico</b>	<b>Dirección</b>

7	German Sanchez Claudia Guzman Darwing Aguilar	Coordinador promotores sociales.	Programa Puerta Abierta	(504)554-3222/0055		Col. Montefresco 27 calle entre 8 y 9 Av. casa 904 SPS
8	Xiomara Moran Katherine	Enfermera Administradora	La Fuerza de Jospice	(504)559-3184		Col San Vicente de Paul, frente a Fabrica de Boquitas Rica Sula
9	Dr. Juan Ramón Gradelhy	Asesor	ONUSIDA	(MT) 220-1100/ 231-0102 Ext. 1682 Fax: 239-7084 Cel.: 984-7353 (JRG)	<a href="mailto:maria.tallarico@undp.org">maria.tallarico@undp.org</a> / <a href="mailto:juan.gradelhy@undp.org">juan.gradelhy@undp.org</a>	
10	Dr. Roberto Trejo	Infectólogo	Hospital Mario Catarino Rivas	cel.: 991-5605		Barrio Lempira, 9a. Calle, 8 y 9 avenidas, No. 29
11	Dra. Rosalinda Hernandez	Directora del Programa Nacional de ITS/VIH/SIDA	Secretaría de Salud	237-4343 Fax: 237-3174	<a href="mailto:rosalinda.hernandez@usa.net">rosalinda.hernandez@usa.net</a>	
12	Lic. Rene Lopez	Director	Fundación Solidaridad y Confraternidad	236-9934 Cel.: 969-6098	<a href="mailto:fundacionlaves@yahoo.com">fundacionlaves@yahoo.com</a>	Ave. Junior, 9 y 10 calle; 4ta. Av. #3, frente a Escuela Soledad Fernandez
	<b>Tegucigalpa</b>					
1	Trudy Perez		Solidaridad y Vida	236-5156 221-0359		Col. Palmira Ave. Rep. De Ecuador Casa #330
2	Dra. Elsa Palou Angela Maria David Adilia Aldana	Servicio de Infect- ología Trabajo Social Microbiología	Hospital Nacional del Tórax	236-8978 236-8849 236-5207	<a href="mailto:palouey@yahoo.com.mx">palouey@yahoo.com.mx</a>	Col. Lara Ave. Los Próceres detrás del PANI
3	Fatima Valle		OPS	221-3721 Fax: 221-3706		Col. Lomas del Guijarro Calle Principal. Edif. Plaza Guijarro 5 piso
4	Dr. Humberto Cosenza	Director Ejecutivo de Cooperación Externa	Secretaría de Salud	222-8520 Cel: 970-0227	<a href="mailto:cosycia@datum.hn">cosycia@datum.hn</a>	
5	Dr. Efraín Bu	Infectólogo	Hospital Escuela	237-3156 Fax: 232-3858	<a href="mailto:efabu@hotmail.com">efabu@hotmail.com</a>	Medicina Interna, Bloque Medico Quirurgico, 1 piso
6	Dr. Enoc Padilla	Director	Asoc. Hondurena Solidaridad y Vida	223-8972 y 86 239-7065	<a href="mailto:enocsyl7@hotmail.com">enocsyl7@hotmail.com</a>	Col Alameda tres casas al Norte de Rescate Medico Móvil, Casa #734 Tegus.

	<b><u>Honduras</u></b>	<b><u>Puesto</u></b>	<b><u>Organización</u></b>	<b><u>Teléfono (504)</u></b>	<b><u>Correo Electrónico</u></b>	<b><u>Dirección</u></b>
7	Dra. Carmen Pérez Samaniego	Proyecto SIDACOM	GTZ			
8	Antonio Girona Nick Silverstein Jean Paul Brouette	Jefe de Misión Coordinador Medico Administrador	MSF	236-5156 221-0359 221-4784	<a href="mailto:msfch-honduras@multivisionhn.net">msfch-honduras@multivisionhn.net</a>	
9	Dra. Odessa Henriquez Rivas	Presidenta	Colegio de Médicos	232-6763/231-0518 Fax:232-6573	<a href="mailto:cmhhon@yahoo.com">cmhhon@yahoo.com</a>	Bld. Miraflores, Centro Com. Centro América, Tegucigalpa
10	Lic. Brenda Melendes Lic.Lilia Meza Dra. Iris Tejeda	Vice Decana, Resp.Curricular, Secretaria de la Facultad.	Facultad de Medicina - UNAH	Tel: 00504 239-5887 232-5922		
11	John Rogosch Dr. Angel Coca	Dir. Oficina de Salud Oficial de proyectos	USAID	236-9320	<a href="mailto:jrogosch@usaid.gov">jrogosch@usaid.gov</a> <a href="mailto:acoca@usaid.gov">acoca@usaid.gov</a>	Ave. La Paz frente a Embajada Americana
12	Dra. Maria Tallarico	Asesora	ONUSIDA	220-1100 231-0102 Ext. 1682 Fax: 239-7084	<a href="mailto:maria.tallarico@undp.org">maria.tallarico@undp.org</a>	

	<b><u>Panamá</u></b>	<b><u>Puesto</u></b>	<b><u>Organización</u></b>	<b><u>Teléfono (507)</u></b>	<b><u>Correo Electrónico</u></b>	<b><u>Dirección</u></b>
1	Dr. Nestor Sosa	Jefe de Infectología	Caja del Seguro Social	Cel.: 613-3750 263-3464	<a href="mailto:nsosa@sinfo.net">nsosa@sinfo.net</a>	Complejo Hospitalario del SS, 6to piso. Hosp.Gral.Infectología
2	Dra. Laura de Thomas	Jefe de ITS/VIH/SIDA	Caja del Seguro Social	262-6269 cel.: 676-7066	<a href="mailto:lthomas@sinfo.net">lthomas@sinfo.net</a>	Calle 17, Policlínica Presidente Ramon, Edif. Admo, 4to piso
3	Dra. Gladys Guerrero	Directora - Programa Nacional de SIDA	Sede del PNS MINSA	212-9321	<a href="mailto:pnsminsa@hotmail.com">pnsminsa@hotmail.com</a>	Minist. De Salud ANCON. Edif. 261 (Programa Nac. De SIDA)
4	Francisco Marin	Trabajador Social	Cooperación Española	212-9321	<a href="mailto:pnsminsa@hotmail.com">pnsminsa@hotmail.com</a>	Minist. De Salud ANCON. Edif. 261 (Programa Nac. De SIDA)
5	Dr. Guillermo Troya		OPS	262-0030	<a href="mailto:verdejog@pan.ops-oms.org">verdejog@pan.ops-oms.org</a> / <a href="mailto:verdejog@paho.org">verdejog@paho.org</a>	ANCON, Ave. Gorgas, Edif. 261, Minist. Salud, 2o. Piso
6	Dr. Orlando Quintero Ariel Muñoz Dra. Yadira Ibarra Dra. Marianela Guerrero Edith Tristan	Director Activista Promoción Depto Proyectos Activista	PROBIDSIDA	225-9119 675-3724	<a href="mailto:probidsida@cwpanama.net">probidsida@cwpanama.net</a>	Calle 31 con Ave. Balboa, entre Restau. Boulevard y gasolineras DELTA, al frente de Multiaire de Panamá.
7	Dra. Eira Garcia Dra. Marixcel Suarez Lic. Marcela Palma	Coord. Comisión de SIDA del Hospital, Jefa de Med.Interna e Infectología, Jefa de Enfermería de Infectología.	Hospital Santo Tomas	Hosp. 225-6269 cel.: 673-2394 Cli.: 229-4730	<a href="mailto:ergarciag@cableonda.net">ergarciag@cableonda.net</a>	Hospital Santo Tomas-Área de Maternidad, Av. Balboa
8	Dra. Amoy Chong Ho Dra. Magaly Zevallos Enf. Amarelis Quintero Lic. Dora Polanco Dra. Karen Holder Enf. Edith Castillo Lic. Rita Tejada	Jefa del Departamento de Atención a la Población, Salud Reproductiva, Niñez y Adolescencia, Salud de Adultos	MINSA	212-9269	<a href="mailto:vigepi@sinfo.net">vigepi@sinfo.net</a>	Corregimiento, Av. ANCON, Calle Gorgas, Edif. 261
9	Dr. Enrique Mendoza Dra. Marion C. Martin	Decano Jefa Departamento de Microbiología	Facultad de Medicina	263-6883 Tel-Fax: 223-8512	<a href="mailto:enriquemen56@hotmail.com">enriquemen56@hotmail.com</a>	Villa transistmica al frente del Complejo Hospitalario

	<b><u>Panamá</u></b>	<b><u>Puesto</u></b>	<b><u>Organización</u></b>	<b><u>Teléfono (507)</u></b>	<b><u>Correo Electrónico</u></b>	<b><u>Dirección</u></b>
10	Licda. Elena de la Motte	Decana-PRODECC	Facultad de Enfermería	264-8869 223-8391 Cel.: 625-7720	<a href="mailto:penfcent@ancon.up.ac.pa">penfcent@ancon.up.ac.pa</a> <a href="mailto:facenf1@ancon.up.ac.pa">facenf1@ancon.up.ac.pa</a> <a href="mailto:facenf2@ancon.up.ac.pa">facenf2@ancon.up.ac.pa</a>	Facultad de Enfermería de Univ. de Panamá, Campus Universitario
11	Elizabeth Fong	Presidente	Grupo Temático ONUSIDA	265-0838 263-1842	<a href="mailto:elizabeth.fong@undp.org.pa">elizabeth.fong@undp.org.pa</a>	Área Bancaria, Av. Samuel Lewis, Edif. Central, piso #1

	<b><u>El Salvador</u></b>	<b><u>Puesto</u></b>	<b><u>Organización</u></b>	<b><u>Teléfono (503)</u></b>	<b><u>Correo Electrónico</u></b>	<b><u>Dirección</u></b>
1	Connie Jonhson Dra. Alba Amaya	Jefa de oficina de Salud Oficial de Proyectos	USAID	298-1666 tel. 298-0885 fax	<a href="mailto:cojonhson@usaid.gov">cojonhson@usaid.gov</a> <a href="mailto:aamaya@usaid.gov">aamaya@usaid.gov</a>	CO Embajada Americana, Final Blvd. Santa Elena Sur, Antiguo Cuscatlan, San Salvador
2	Dr. Armando Bañuelos Rolando Pinel		OPS	222-0021, 3306 fax: 298-1168	<a href="mailto:abanuelos@els.ops.oms.org">abanuelos@els.ops.oms.org</a>	73 Ave. Sur y Ave. Olímpica #135 Colonia Escalón
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7	Dr. Mauricio Magaña Dra. Elizabeth de Viana Dr. Guillermo Ortiz Enf. M. Carmen Montano Lic Margarita de Chavez Lic. Margarita de Castillo Lic. Estela de Recinos Otras 7 personas	Director Infectóloga Pediatra Obstetra Alto Riesgo Jefa Enfermería Jefa Trabajo Social Jefa Laboratorio Psicóloga	Hospital de Maternidad	Cel.: 829-1499 (EdV) Tel.: 221-4723 Fax: 222-0105	<a href="mailto:dianita2@hotmail.com">dianita2@hotmail.com</a>	Final 1 calle poniente y 25 Ave. Norte, Hosp.Nac. De Maternidad Raúl Arguello Escolan, Centro Medico Nacional

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7	Dr. Francisco Cerezo Dr. Marco Pérez Dra. Judith García	Director del Programa TB Jefe Dept medicina (TBC) Resp SIDA/TBC	MSPAS Hospital de Tuberculosis San Vicente	471-6546 fax: 475-2121 471-0311/12		Finca La Verbena, 11 Ave. "A" 12-30, zona 7

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10	Ismar Ramirez Luis Cuscul	Proyecto Derechos Humanos	Fundación Fernando Iturbide	332-3350 331-1698		
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13	Dr. Cesar L. González	Presidente	Asoc. De Infectólogos	Cel.: 318-9961		
14	Dr. Gustavo Castillo Aura Melgar Ricardo Garcia Aida Aguilar	Infectólogo Adultos Psicóloga Trabajadores Sociales	IGSS / Hospital de Infectología	220-8679		
15	Dra. Zonia Pinzon	Directora Medica	Centro de ref. de ITS			
16	Ana Lucía Saravia de Estrada	Directora	Hogar Marco Antonio	334-4752	<a href="mailto:walestrada@guate.net">walestrada@guate.net</a>	5a. Ave. 8-33, zona 4
17	Dr. Rubén Mayorga	Director	OASIS	220-1332 253-3453	<a href="mailto:oasisgua@inteln.net.gt">oasisgua@inteln.net.gt</a>	6a. Ave. 1-63, zona 1
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3	Dr. Carlos Quant	Infectólogo	Hospital Roberto Calderón (MINSA)	088-09635 249-6346	quantc@datatex.com.ni	Centro Diagnostico Siglo XXXI, costado Sureste de Galería Internacional
4	Dr. Gustavo Sequiera	Director de Investigación	UNAN-Managua	088-79202		
5	Dra. Lesbia Altamirano	Consultora	OPS/Nicaragua	289-4200	altamiranol@nic.ops-oms.org	Apartado Postal 1309, Complejo Nacional de Salud "Conchita Palacios", Managua
6	Sra. Flor de Maria Alvarado	Ex-presidenta	ASONVISIDA		fmariaalavarado@yahoo.com	
7	Lic. Pasquall Ortells	Director adjunto (?)	Fundación Nimehautzin	278-0028	nimehaut@aol.com	Reparto Lomas de Guadalupe, porton UCA 1 cuadra al este, 1 1/2 al Sur No 68, Managua



### **Annex 3: Clinical Site Summary Sheets**

#### **Clinical Site Summary Sheet Hospital Mario Catarino Rivas San Pedro Sula, Honduras October 16, 2002**

##### **Current role in health system:**

Hospital Catarino Rivas is a 550-bed, tertiary care hospital in the Ministry of Health system that provides care to patients referred from the northern parts of the country as well as secondary-level hospital care to residents of San Pedro Sula and the surrounding region. It is a general hospital with medical, surgical, obstetric, and pediatric inpatient services, as well as a broad range of general and specialty clinics onsite.

##### **Current commitment to HIV care:**

Until recently, the majority of HIV care was provided in the inpatient setting to HIV-infected individuals with advanced disease who presented with acute opportunistic complications. Patients were managed in one of the infectious disease rooms on the male and female medical wards. Two infectious disease physicians share the responsibility for treating the HIV-infected inpatients. An outpatient clinic has been operational over the last few years, but with the availability of ARV therapy in July 2002, more people have been seeking ambulatory services at the hospital. The clinic is open five days a week from 7 a.m. to 1 p.m. Only one examination room is available. A physician and one nurse staff the clinic and 15 to 20 patients are seen each day. Social work services are available through the hospital, but they are primarily involved in financial assessments to evaluate the patient's ability to pay for services.

It is estimated that approximately 180 adults are in care in the outpatient clinic; 80 of these patients receive ARV therapy. Patients on ARV therapy are asked to return for weekly visits. Approximately 60 HIV-infected children are followed through the pediatric clinic, located in Catarino Rivas. Fifteen of these are on ARV therapy.

##### **Current resources available for HIV care:**

*Personnel:* Two infectious disease specialists to treat inpatients and one physician and one nurse in the outpatient clinic.

##### *Medications:*

*Laboratory:* Routine laboratory tests are available, including CBC, chemistry, RPR, and routine X-rays. CD4 cell counts are done onsite, but viral loads must be sent to Tegucigalpa to a private lab. CT scanning is available with substantial co-pay. There is no database on which to track patients. A record of adult patient visits is kept by hand in the clinic office.

*ARV Agents:* AZT+3TC and Efavirenz are the only available combination.

**Planned expansion of HIV care over the next one to two years:**

An increase in the availability of ARV agents is planned over the next year. It is very probable that more patients will be looking for outpatient care at the hospital. Hospital sources estimate that 100 new patients may be started on ARV therapy in the next 12 months. So far, it does not appear that any additional resources have been committed for personnel, space, and equipment or case management. It is possible, though it has not been spelled out, that Global Fund resources may be available to expand these services.

**Potential role of this site in a comprehensive HIV care network:**

Given the prior experience with the management of symptomatic HIV infection, the presence of two infectious disease physicians, the growing experience with ARV therapy and the central role in the Ministry of Health system, Catarino Rivas may serve as a regional center for HIV care and hospitalization. It may serve as an initial center for ARV therapy in the northern part of the country, but a plan to move some of this care out into the secondary level might make sense.

It appears that additional resources and training will be needed in order to prepare the HIV program at Catarino Rivas to expand its services and to provide consultative back-up for primary and secondary level providers.

Person interviewed: Dr. Roberto Trejo.

**Clinical site summary sheet**  
**Centro de Salud Miguel Paz Barahona**  
**San Pedro Sula, Honduras**  
**October 17, 2002**

**Current role in health system:**

The Centro de Salud Miguel Paz Barón is a neighborhood health center located in a working class neighborhood of San Pedro Sula. It provides primary care to the residents of the city to the east of the city center. In addition to primary health care teams, the clinic has a pharmacy, a TB clinic, and some social support services.

A prominent component of the clinic is an active STI clinic that offers services primarily to women and to CSWs in particular. The STI clinic is open five days a week from 7 am until noon. It is staffed by two physicians, two nurses, and other ancillary personnel. About 20 to 30 patients are seen per day and they receive preventive, diagnostic, and treatment services. Patients, who require more sophisticated care or those who are ill, are sent to Hospital Mario Catarino Rivas, also in San Pedro Sula.

**Current commitment to HIV care:**

The physicians at the STI center believe they follow about 20 HIV-infected adults. There are no specific therapies available for these individuals and, if symptomatic, they are referred to Catarino Rivas for care. The physicians are interested in being more involved in HIV care and in offering services onsite.

**Current resources available for HIV care:**

There are no HIV-specific resources available at this time; however, medical care, gynecological care, and other preventive services are offered to this high-risk, inner-city population with a high prevalence of CSWs. According to the clinic staff, the patients are comfortable coming to the center and often identify the center as their preferred source of health care.

**Planned expansion of HIV care over the next one to two years:**

There are no specific plans for expansion of HIV care at this site at this time.

**Potential role of this site in a comprehensive HIV care network:**

This health center and the STI clinic might be an ideal pilot site for an HIV treatment facility based in a primary care setting. There are physicians and staff with experience in STI care serving a high-risk population, and the setting is convenient to patients' homes. In addition, there are natural referral arrangements already in place with Hospital Catarino Rivas that provides specialty HIV care within the city.

Persons interviewed: Dr. Amanda Sevilla; Dr. Juana Aldana.



**Clinical site summary sheet**  
**Hospital del Instituto Nacional del Tórax**  
**Tegucigalpa, Honduras**  
**October 17, 2002**

**Current role in health system:**

Hospital del Torax is a specialty center in respiratory diseases. In 1987, the first AIDS treatment unit was created in this center. The infectious disease unit has 30 beds in five rooms and two extra rooms, one for outpatient consultation and another for meetings and multipurpose activities. The hospital is composed of various buildings in an open space. In one year, the outpatient department case load increased 3.5 times, from 90 patients in September 2001 to 333 in September 2002. There has been no increase in assigned staff.

**Current commitment to HIV care:**

Inpatients are closely followed up by the head of the unit. At the time of the visit, the unit was fully occupied with severely ill patients. They get referrals from the whole country mainly with respiratory problems and tuberculosis. There were also several persons admitted with neurological problems, such as toxoplasmosis, criptococcosis, and TB meningitis. Another pathology frequently found is hystoplasmosis. There were several patients in day treatment with IV Amphotericin B because Itraconazole is not available. Average occupation rate is 80 percent; average length of stay is 25 days; and, in the last five months, there were eight deaths.

There is a self-help group named "Triunfando con VIH+," linked with the outpatient clinic. It is coordinated by a social worker. Among its members are 50 people living with HIV/AIDS and 50 family members. The group helps support the clinic by organizing fundraisers.

**Current resources available for HIV care:**

*Personnel:* Two physicians (one specialist in infectious diseases and a generalist with training in HIV/AIDS); one graduated nurse trained in AIDS and counseling, nine auxiliary nurses, and two social workers. They may request support from other professionals in the hospital, such as pharmacists, microbiologists, pediatricians, and respiratory physicians.

*Medications:* Routine antibiotics for bacterial infections, TB treatment, and pneumocystis carinii pneumonia (PCP) prophylaxis are almost always available; Fluconazole is often unavailable and MAC prophylaxis and Itraconazole are rarely available. Certain drugs are obtained irregularly as donations. There is oncological treatment (Kaposi sarcoma and lymphoma).

*Laboratory:* There is a good quality laboratory with most basic tests and certain specialization in respiratory testing, including Adenosine Dyaminase (ADA), chemistry (manual techniques), and routine X-rays are always available. Toxoplasma and cytomegalovirus serology tests are not available. Since July 2002, a new FACSCOUNT CD4+ cell counts machine has been installed, doing 24 tests a week; they regularly have problems with reagent supply. CT scans are done externally with a 50 percent payment reduction; viral loads are available at a private laboratory costing \$US100 each. They do not use viral load as a guide for treatment, but samples are being prepared, frozen, and stored.

*ARV agents:* ARV treatment started in June 2002. At present, 35 persons are in treatment. AZT+3TC and Efavirenz are the only drugs available at this time. During the visit, there was one young woman with anemia caused most probably by AZT. No alternative treatment was available for her outside the private market.

**Planned expansion of HIV care over the next one to two years:**

The head of the AIDS unit submitted a proposal to the Ministry of Health to organize a continuous training program to help expand treatment beyond the present clinics and hospitals. From November on, they will have 200 new treatments authorized by the ministry. AZT+3TC and Efavirenz have already been purchased. In future budgets, more ARV drugs will become available.

**Potential role of this site in a comprehensive HIV care network:**

This clinic has good potential to be a center of in-service training for different health staff in clinical aspects. The clinic director has submitted the only concrete training proposal in all of the visited countries. She offers to organize one-month courses combining theoretical and practical aspects considering the need for comprehensive care by promoting linkages with other institutions. The clinic could be the referral center for a pilot project of decentralization.

Persons interviewed: Dr. Elsa Palou Infectious Diseases Specialist, Head of the Unit; Adilia Andara, Microbiologist; Angela Maria David, Social Work Coordinator.

**Clinical site summary sheet**  
**Hospital Escuela**  
**Tegucigalpa, Honduras**  
**October 18, 2002**

**Current role in health system:**

Hospital Escuela is the principal teaching and tertiary care facility in the Ministry of Health system in Honduras. It acts as a referral center nationwide as well as serving as the tertiary care facility for the south of the country and as a secondary hospital for the city of Tegucigalpa. It has almost 1,000 beds and has services that cover medicine, surgery, obstetrics, pediatrics, and most sub-specialties. It has outpatient clinics in most of these areas. Like much of the Ministry of Health system, the clinical services frequently face shortages of supplies, equipment, and medications.

**Current commitment to HIV care:**

Hospital Escuela has been the central focus of clinical HIV care for medically indigent people in Tegucigalpa and, along with a hospital in San Pedro Sula, within the country. The majority of care has been hospital based and directed toward the acute management of individuals with opportunistic complications of their disease who present for emergency care. The majority of hospitalized adults are managed by the Department of Medicine in 18 infectious diseases beds distributed across six medical wards. Patients are managed by house staff and attending internists, under the supervision of the infectious disease physician who also happens to be the chairman of the Department of Medicine.

In addition to inpatient care, there is a clinic devoted to the outpatient management of HIV which is held four days a week from 7 a.m. to 1 p.m. Two sessions are for adult patients and two are for children. ARV agents have only recently been available (July, 2002). Prior to that, patients were irregularly followed in the clinic and treated when they presented with symptoms. Now, approximately 36 adults receive ARV therapy, and they are seen weekly by clinic staff to ensure adherence. They are seen by the physician biweekly and have access to a pharmacist and a dietitian. Prior to starting on ARV medications, each patient undergoes a multidisciplinary evaluation to ensure that use of the drugs is appropriate. Treatment is offered to patients based upon the guidelines developed by the Pan American Health Organization support groups affiliated with the program meet onsite during clinic hours.

**Current resources available for HIV care:**

*Personnel:* Two physicians for adult care and one for pediatrics (each has many other commitments), one nurse, one social worker, a dietitian, and a pharmacist.

*Medications:* Routine antibiotics for bacterial infections, TB treatment, and PCP prophylaxis are almost always available; Fluconazole is often unavailable and MAC prophylaxis and Itraconazole are rarely available.

*Laboratory:* CBC, chemistry, RPR, and routine X-rays are always available; PPD testing has been scarce; CD4 cell counts are done at Thorax Hospital; CT scans are done with co-pay; viral loads are rarely available (available at one private laboratory)

*ARV agents:* AZT+3TC and Efavirenz are the only drugs available at this moment. Thirty-six adults are in treatment.

**Planned expansion of HIV care over the next one to two years:**

Since Honduras has plans to expand the number of patients to 1,000 on ARV therapy over the next year, Hospital Escuela plans to expand from 36 patients to approximately 200 to 300 patients in that period. The medications will be purchased by the Ministry of Health and dispensed through the hospital pharmacy. Plans are already underway to refurbish a pre-existing pediatric oncology ward into a new outpatient HIV care center. The facility is located within the hospital and would greatly expand the space for exam rooms, IV infusions, counseling, and support services.

The lack of trained personnel is main impediment to expansion at this time now that ARV agents will be more available. The director, who is also the Chairman of Medicine, has limited hours and only limited physician backup. Training needs and patient care needs will require additional physician time. If the clinical facility is to expand, additional nurses, social workers, and other staff will be needed.

**Potential role of this site in a comprehensive HIV care network:**

Hospital Escuela, and its inpatient and outpatient care areas are currently the referral centers for central and southern Honduras and the city of Tegucigalpa. With the planned expansion of the HIV program, Hospital Escuela is a natural place to serve as the center of an HIV care network in Honduras. Outpatient care of difficult patients and those who require subspecialty care could be delivered within the clinics. In the early phases of a program, routine HIV care might be offered onsite, but as the network matures some of that care might be transitioned to primary and secondary sites closer to the patients' residences. Inpatient care, laboratory support, and professional education could occur onsite at Hospital Escuela.

Person interviewed: Dr. Efrain Bu

**Clinical site summary sheet**  
**Solidaridad y Vida**  
**Tegucigalpa, Honduras**  
**October 18, 2002**

**Current role in health system:**

Solidaridad y Vida is a freestanding HIV treatment and support organization founded by the physician Enoch Padilla in 1996. It is located in downtown Tegucigalpa. Outpatient medical care is offered onsite, and the program has linkages to a large network of NGOs, which offer psychosocial support, laboratory testing, pediatric care, services for orphans, hospice, and access to donated ARV agents. The organization is led by a board of directors and an unsalaried executive director (Dr. Padilla).

Solidaridad y Vida receives referrals from many organizations and it, in turn, refers its sickest patients to local hospitals for inpatient treatment including Hospitals Escuela, Torax, Carmen, and San Jorge. Over the years, it has developed financial support from a number of international organizations including UNICEF, the Dutch Embassy, the European Union, and pharmaceutical companies. The organization receives no funding from the Honduran health care system; instead patients in treatment are asked to support the activities of the center with a monthly payment that is based upon the patient's ability to pay.

**Current commitment to HIV care:**

Solidaridad y Vida was created to meet the needs of HIV-infected Hondurans who had nowhere else to turn for medical care, access to medications, and support services. The organization appears to have remained focused on these goals and appears to have created a broad coalition with other organizations to address the many problems faced by their patients. Orphans without other options are sent to Nuestros Pequeños Hermanos, an orphanage supported in part by European funds. Of 860 children in care there, 82 have been orphaned by HIV. Of these, 18 are HIV-infected, and 12 are on ARV therapy.

Of the HIV-infected individuals who are currently followed by Dr. Padilla, 12 are able to afford proprietary name brand ARVs; 32 are on generic drugs; 10 receive drugs through a local NGO; and 28 routinely receive drugs from the U.S.

The costs of laboratory testing must all be covered, but Solidaridad y Vida has been able to negotiate favorable pricing strategies, such as CD4 cell counts for \$30 and viral load testing for \$100.

In addition to care and support, Dr. Padilla has been doing training in the area of Comayagua, a province outside of Tegucigalpa with a growing number of HIV cases and the potential to develop some HIV care infrastructure.

**Current resources available for HIV care:**

The organization operates on very little funding and with very few resources. Dr. Padilla's activities within the organization are largely subsidized by his small private practice. His ability to

focus on the key issues facing HIV-infected Hondurans and his ability to create coalitions to address some of the most pressing needs have allowed his organization to continue to operate despite the economic difficulties.

**Planned expansion of HIV care over the next one to two years:**

Without the promise of new funds in the near future, it will be hard for Solidaridad y Vida to expand, despite the increasing demand for its services. The increased availability of generic medications and the relative lack of physicians with experience in HIV care may, in fact, increase demand for care from the middle and working classes through the program.

**Potential role of this site in a comprehensive HIV care network:**

Although Solidaridad y Vida works outside the traditional health care system, it shares a number of its clients with Ministry of Health and social security clinics and hospitals. Dr. Padilla and some of the organizations he collaborates with may have as much experience with the management ARV agents as anyone in the country. This organization might fit in as a primary care site that might be linked to a tertiary care center in a more formal way. Alternatively, the group might be funded to provide more in the way of support services to enhance adherence to medications and to encourage follow-up at the more traditional health facilities.

Person interviewed: Dr. Enoch Padilla

**Clinical site summary sheet**  
**Complejo Hospitalario del**  
**Instituto Panameño de Seguridad Social (IPSS)**  
**Servicio de Enfermedades Infecciosas**  
**Panamá City, Panamá**  
**October 21, 2002**

**Current role in health system:**

The Hospital of the Instituto Panameño de Seguridad Social is the main referral center of the social security system in Panama. It cares for most AIDS insured patients in the country because the only other hospitalization service is in Colon. It is a third and fourth level care hospital and has direct links with the University of Panama including use as a training institution. The social security system in Panama covers 70 percent of the population.

**Current commitment to HIV care:**

The hospital has a specialized clinic for outpatient follow-up of HIV/AIDS cases and ARV therapy and has had full coverage of insured persons since October 1999. There is a specific infectious disease ward with 23 beds fully dedicated to HIV/AIDS. Other infectious diseases are directed to internal medicine wards. They have a program of prevention of mother-to-child transmission following the protocol ACTG076, and, since the month of September 2002, triple therapy has been standard (still to be spread to other health units of the social security system). They coordinate a centralized PEP program too.

At present there are 869 persons in ARV treatment of whom 48 are children. Main opportunistic infections found in 2001 were TB (26.7 percent), wasting syndrome (16.6 percent), toxoplasmosis of the brain (11.5 percent), hystoplasmosis (10.2 percent), and pneumocystis carinii pneumonia (7 percent). Only one case was infected by perinatal transmission in 2001. The mortality rate attributed to AIDS among the insured population has been reduced by more than one-half since the generalization of triple therapy.

**Current resources available for HIV care:**

*Personnel:* The center is well staffed.

*Medications:* Most IO drugs are available, even Gancyclovir.

*Laboratory:* All routine laboratory tests are available, including CD4+ cell counts (flow cytometry) and viral loads (COBAS Amplicor). CT scanning is available, but nuclear magnetic resonance scan must be done externally. They have diagnostic means for almost every OI, including BACTEC for TB. They do not perform resistance testing to ARV drugs. There is a detailed database maintained by the epidemiology department, which searches for active cases among patients' contacts.

*ARV Agents:* AZT+3TC and Efavirenz are the initial combination. There are other ARV available (ddI, d4T, IDV+RTV, Nelfinavir, and recently LPV+RTV). About 30 percent of patients have to take second-line treatment.

**Planned expansion of HIV care over the next one to two years:**

It is planned to increase decentralization of services over the next year. The social security system has 12 regional hospitals, 26 specialty clinics, and 14 local units of primary health care. Often in the provinces, social security shares health structures with the Ministry of Health. Two doctors (from Colon and Chiriqui) are being trained in Spain. A pediatric hospital will be opened soon.

**Potential role of this site in a comprehensive HIV care network:**

This is a center with international level of care. Well staffed and with adequate means, it has a convenient location in front of Panama University. At present, it has training functions and has been involved in the management of a course on AIDS and other infectious diseases.

This center could be a good place for training human resources from other Central American countries to expand ARV treatment coverage.

Persons interviewed: Dr. Nestor Sosa, Head of Infectious Disease Department; Dr. Laura Thomas, Director of Epidemiology

**Clinical site summary sheet  
Hospital de Santo Tomas  
Panamá City, Panamá  
October 22, 2002**

**Current role in health system:**

Hospital Santo Tomas is the principal referral center in the Ministry of Health system. It covers mainly the four health areas of Panama City and the Darien Region. Other regions (Asuero, Chiriqui, Colon) are starting to organize their own AIDS treatment programs, even if they are limited due to lack of CD4+ and viral load tests. It is a complex of historic and new buildings undergoing a major renovation. It is located near the sea, between the old and new Panama Cities.

**Current commitment to HIV care:**

The hospital has created an internal AIDS commission to organize care for PLWHA. Admitted HIV-positive patients are distributed among different services according to their needs. There is one isolation unit with 17 beds. This unit is dedicated to active TB cases or to those who need to be isolated. There is also a daycare unit and an AIDS OPD clinic.

In the six first months of 2002, they registered 124 discharged patients of which 54 percent were from the isolation unit, 15.6 percent from three internal medicine services, and 10 percent from the respiratory unit. The specialists in infectious diseases act as advisors to the other services. In 2001, they registered 382 discharges.

In 2001, the exit OI diagnosis was: seven TB, 56 candidiasis, 51 PCP, 42 central nervous system toxoplasmosis, 19 hystoplasmosis, 17 wasting syndrome, seven cryptococcosis, and four Kaposi sarcoma.

Ten pregnant women were attended in 2002; six are still being followed. Twenty-seven were attended in 2001.

The hospital has close links with the Hospital del Niño where newborns are referred. Hospital del Niño has an excellent reputation but could not be visited. There are four specialists in infectious diseases and 121 children in ARV treatment. They also do research on treatment.

At present there are 62 persons in ARV treatment provided by the government. There are also 64 persons included in a study by a pharmaceutical company.

They face difficulties in the emergency department and with surgeons because of certain discriminatory attitudes of the staff, but this has improved over time. Sometimes they follow patients up with home visits.

**Current resources available for HIV care:**

*Personnel:* Three infectious disease specialists, seven graduate nurses, four auxiliary nurses, two psychiatrists, one social worker, one nutritionist, two pharmacists, two secretaries, one cleaner, and one guard. There are also two intern students and one resident in internal medicine.

*Medications:* Most drugs for OIs are available, except Azythromycin and Rifabutin.

*Laboratory:* Laboratory equipment is sufficient. Until May, there was a problem with flow cytometry for CD4+ and they were sending samples (and reagents) to the Social Security Hospital, but it has been solved. For viral load, the method used is NASBA Nuclisens, located in Instituto Conmemorativo Gorgas. The cost to the public is \$US100 each. There are possibilities for exemption. NMR is only available externally.

*ARV Agents:* Basic ARV treatment protocol is AZT+3TC and Efavirenz or Indinavir. It costs \$US1600 per person per year. They have also d4T and ddI.

**Planned expansion of HIV care over the next one to two years:**

The national AIDS program aims to decentralize care and treatment setting up four regional AIDS clinics: one for Panama (four health areas: Metro, east, West, and San Miguelito); one in Colon; one in Chiriqui (including Bocas del Toro and Ngobe-Bugle); and one in Los Santos (including Herrera, Cocle, and Veraguas).

**Potential role of this site in a comprehensive HIV care network:**

It is the natural referral center for the Ministry of Health system. AIDS treatment is well integrated into the daily life of the hospital. It has good links with the Hospital del Niño and may be a good place for training once renovations are completed.

Persons interviewed: Dr. Eyra Garcia, Head of Infectious Diseases; Enf. Marcela Palma; Dr. Marixcel Suárez, Head of Internal Medicine Department

**Clinical site summary sheet  
Hospital de Maternidad  
San Salvador, El Salvador  
October 24, 2002**

**Current role in health system:**

Hospital de Maternidad attends 19,000 deliveries a year; 4,000 of them are considered high risk. Each month, 98 pregnant women get tested for HIV among 1,650 deliveries. Antenatal consultation coverage is 40 percent. The hospital was damaged during the earthquakes of January and February 2001 and lost some capacity.

**Current commitment to HIV care:**

With the support of Medecins Sans Frontieres since June 2001, the Maternity Hospital promoted a program to prevent mother-to-child transmission. As of October 2002, 89 HIV-positive women were included in the program, and 3,080 counseling sessions were done in one year for 121 patients (HIV-positive women and their husbands). Since the beginning of 2002, 38 group support sessions with an average participation of 17 persons have been organized with pregnant women and their families. The program is linked with 11 peripheral health centers.

**Current resources available for HIV care:**

*Personnel:* There is a multidisciplinary team active in the program. It is coordinated by a perinatal infectious disease specialist, and there are four OBGYNs (caring for high-risk deliveries), nurses, social workers, psychologists, pharmacists, microbiologists, an epidemiologist, nutritionists, and an individual responsible for the blood bank.

*Medications:* They have standard treatments for infections. More complex PCP prophylaxis or specific OI treatment needs have to be referred.

*Laboratory:* There are specialized exams for STI and HIV (two different ELISA tests). Viral load results take two to three weeks and have been done on 44 pregnant women. The test is available at the national laboratory, as is CD4+ count.

*ARV agents:* The hospital started applying the protocol ACTG076 (AZT from the 14th week of pregnancy) and, to include women without previous diagnosis, also introduced the protocol HIVNET012 (Nevirapine during delivery). Results between June 2001 and October 2002 were 41 women had finished ACTG076; 20 women were still in treatment with ACTG076, 12 women were receiving protocol HIVNET012, and 16 women were receiving triple therapy (AZT+3TC and either Nevirapine or Nelfinavir). Four children were found to be HIV-positive with viral load testing. Of those, one was detected after delivery and two had problems with treatment compliance.

**Planned expansion of HIV care over the next one to two years:**

MSF will end their support by June 2003. At that time, the hospital supported by the national AIDS program plans to extend the program and to increase the coverage (100 person to be tested as of January 2003). This will be achieved through increased decentralization.

**Potential role of this site in a comprehensive HIV care network:**

The Maternity Hospital in El Salvador has an important role in promoting adequate and quality PMTCT. It is naturally linked with the Pediatric Hospital Bloom (good references though not visited), and with the clinics in Hospital Rosales (see below) and Zacamil in San Salvador.

This hospital and the PMTCT clinic must be involved in the network to provide specialized care to pregnant women. It should be considered as an essential training post for supporting decentralization of comprehensive care.

Persons interviewed: Dr. Elisabeth de Viana, Neonatologist and Infectious Diseases Specialist, Coordinator of the Unit; Marina Montano, Head Nurse; Margarita de Chávez, Head of Social Work; Guillermo Ortiz, Cristina Rivas, and Rafael Baraona, Gyneco Obstetricians; Jose Mauricio Magaña, Hospital Director

**Clinical site summary sheet**  
**Hospital Rosales**  
**San Salvador, El Salvador**  
**October 25, 2002**

**Current role in health system:**

Hospital Rosales celebrated its 100<sup>th</sup> anniversary in 2002. It has 400 beds. It consists of big open wards connected by corridors with much free space. The earthquakes did not affect the original structure even though some newer concrete buildings were damaged. It is the main referral hospital in the Ministry of Health structure and it is a teaching hospital for the national university. The first AIDS case in El Salvador was diagnosed in this hospital in 1984, and most cases have been attended here. AIDS has become the fourth leading cause of death and the ninth most common diagnosis at discharge. There is currently one HIV diagnosis a day. The caseload attended is 500 people.

**Current commitment to HIV care:**

In response to the growing demand in the early 1990s, the hospital created the first ward devoted to AIDS as well as the first exclusive HIV/AIDS outpatient clinic. In 1998, they set up the first PEP program for health workers in the public sector. The same year the hospital created a committee with medical, paramedical, and administrative personnel to identify and to meet the patients' needs. They identified two priorities: psychological, social, and nutritional support and prevention, diagnosis and treatment of OIs. The hospital has the oldest and largest support group in the country as well as individual and pre- and post-test counseling. Nutritional support has been extended to ambulatory patients. There is an academic program for students, interns, and residents. In December 2000, ARV therapy was introduced. There are 50 persons in ARV treatment with 80 percent adherence. The biggest obstacle has been complexity of treatment, not side effects.

**Current resources available for HIV care:**

*Personnel:* There is a multidisciplinary team involved in HIV care though most of them have other functions. One physician, two nurses, and two social workers are involved full time. A pharmacist ensures adherence control.

*Medications:* Most antibiotics for bacterial infections, TB treatment, and PCP prophylaxis (Fluconazole, Itraconazole, Ciprofloxacin, Amphotericin B, and Pirimetamine) are available. Sulfadiazine and Gancyclovir are unavailable and Folinic acid is reserved for oncology. For nutritional supplementation, they administer Ensure to patients who weigh fewer than 100 pounds.

*Laboratory:* Patients pay \$US6 for HIV testing but can be exempted. In the blood bank, all bags are screened for HIV, hepatitis B and C, Chagas and syphilis (RPR). Routine hematological tests are available as PPD. CD4 cell counts are done at the national central laboratory and are considered sufficient to start ARV therapy. Viral load is recommended for monitoring.

*ARV agents:* AZT, 3TC, d4T, ddI, Efavirenz, Indinavir, and Nelfinavir are available. They have started using the combined formulation of AZT+3TC, which decreases the number of tablets for first-line treatment (five a day instead of 11).

**Planned expansion of HIV care over the next one to two years:**

By next year they expect to double the number of persons in ARV therapy (100).

**Potential role of this site in a comprehensive HIV care network:**

Hospital Rosales is currently the main national referral center. There is a planned expansion and decentralization of ARV treatment and AIDS care that will need adequate training facilities for future staff. This hospital has a well-organized registry of AIDS and HIV cases with new computing equipment and an adapted treatment and training program which could also be used as a regional model for in-service training. Hospital Rosales is well placed to continue serving as a referral center for the most complicated aspects of the disease. El Salvador is a small and well-connected country that has a good chance of creating an effective network of services.

Person interviewed: Dr. Rolando Cedillos, Chief of Infectious Diseases and HIV/AIDS Program

**Clinical site summary sheet  
Hospitales del Seguro Social  
San Salvador, El Salvador  
October 25, 2002**

**Current role in health system:**

The social security system has five centers for AIDS treatment. The team visited the oncology unit, which is an annex to the Medical Surgical Specialty Hospital. AIDS was first treated in oncology because of the existing expertise for immune-depressed patients and to "disguise" the disease to avoid outside discrimination. Recently the main caseload has been transferred to the Specialty Hospital.

Pregnant women and children up to 18 months are being followed at Zacamil Hospital. There is also an outpatient clinic in the Atlacatl Unit and a decentralized center (second-level hospital) in the San Miguel department.

**Current commitment to HIV care:**

Social security started treating pregnant women in 1997 for PMTCT. In 2000, 28 adults started receiving ARV therapy, and in 2001, it became increasingly generalized. By the end of October, 428 adults and seven children were receiving treatment.

Twice a month, the social workers from the treatment team hold PLWHA meetings at the hospital auditorium for group sessions about hygiene, self-care, and adherence. An average of 25 persons attends each one. Peripheral units are linked with the central clinics.

**Current resources available for HIV care:**

*Personnel:* Each clinic has one physician, one psychologist, and one social worker. There are also part-time nurses, nutritionists, lab technicians, pharmacists, and others.

*Medications:* Most drugs needed for OIs are available. They do not use Sulfadoxin and do not have Dapsone (no offers in the country). Nifurtimox is available sometimes.

*Laboratory:* Basic tests are available (hematology and chemistry). They are planning to introduce polymerase chain reaction (PCR) testing for hystoplasmosis and TB. Toxoplasmosis testing is done at the maternity hospital. CD4+ count is done in the U.S., but they are planning to introduce a FACSCALIBUR machine (also useful for other white cell specialized counts). Viral load is done at the hospital with a Q PREP PREAMPLICOR. The central laboratory is able to offer quality control to others.

*ARV agents:* AZT, 3TC, d4T, ddI, Efavirenz, Indinavir, and Nelfinavir are available. There are plans to include ABC, Nevirapine (for prevention of MTCT), and the combined Ritonavir+Lopinavir. They do not have combined AZT+3TC. By using separate drugs (AZT 100 mg instead of 300), they have a more complex dosage for the basic combination of triple therapy (11 tablets a day instead of five).

**Planned expansion of HIV care over the next one to two years:**

The social security system in El Salvador is undergoing reform, and during the visit there was a strike by the health personnel. The outcome at this stage is not predictable, but plans are to increase coverage by training personnel and by decentralizing HIV care. El Salvador started negotiations to obtain reduced ARV prices from the pharmaceutical industry.

**Potential role of this site in a comprehensive HIV care network:**

The network is already organized within the system. It needs to be reinforced, expanded, and decentralized. The reform underway has introduced a level of uncertainty.

Persons interviewed: Dr. Jose Viana, Specialist in Infectious Diseases; Lic. Elizabeth de Melara, Social Worker; Lic. Carolina Andrade, Laboratory Technician

**Clinical site summary sheet  
Hospital Roosevelt  
Guatemala ciudad, Guatemala  
October 30, 2002**

**Current role in health system:**

Hospital Roosevelt has 900 beds and covers one-half of the country as a referral center for the Ministry of Health.

**Current commitment to HIV care:**

The outpatient clinic is supported by MSF, which provides staff and drugs (both ARV and IOs) and follows a cohort of PLWHA in ARV therapy. They have 385 regular patients and another 400 irregulars. Between January 1 and October 15, 2002, 420 new cases were detected. Their workload has increased markedly since starting ARV therapy, and currently there are 40 to 50 consultations a day.

Patients are admitted mainly in the internal medicine department, and if there are no free beds, they may be hospitalized in other services. AIDS fluctuates between the second and third cause of admission in internal medicine among men and fourth to fifth among women. An average of 15 persons is hospitalized increasing to 35 during some periods. All admitted patients who are tested for HIV pass through the clinic to receive pre-test counseling. Discharged persons also pass through the clinic before leaving the hospital.

**Current resources available for HIV care:**

*Personnel:* One head of service, three physicians, two pharmacists, one graduate nurse, one auxiliary nurse, one psychologist, one biologist, one social worker, two laboratory technicians, and one receptionist. Four health volunteers care for hospital and home visits.

*Medications:* Most medications are available for inpatients with the exception of Gancyclovir, Pirimetamine alone (they have only the fixed drug combination with Sulfadoxine), Folinic acid, and Rifabutine. When patients are discharged, they have to buy their own drugs, but MSF provides drugs for prophylaxis.

*Laboratory:* There is an automatic hematology testing machine (Sysmex SE 9500) with 400 tests a day on average. Biochemistry is also automated (28 different analysis). Serology with four automatic machines (two CobasCore, VIDAS and AXSYM) can detect hepatitis A, B, C, toxoplasmosis, cytomegalo virus (CMV), and Chagas, among others. VDRL is read in a plate. For TB, they use the Kinyoun stain and Lowenstein-Jehnsen culture. The BACTEC is out of use because they lack certain reagents. CD4+ cell counts are \$US11. The FACSCALIBUR machine is located in a private hospital. AMEDESQUA and viral load, (\$US170) with COBAS AMPLICOR are done at another private, not-for-profit laboratory (CERICAP). Tomography (\$US35) and NMR (\$US100) are also done externally.

*ARV agents:* ARV treatment provided by MSF started in August 2001, and by the end of October 2001, 115 persons were included. Prior to this, there were 35 patients in study protocols and 15 who paid for their drugs. MSF is providing generic drugs. AZT+3TC and Efavirenz are the first-

choice combination. Other ARVs used are d4T, ddI, Nelfinavir, Indinavir, and Ritonavir (mainly used as a booster).

**Planned expansion of HIV care over the next one to two years:**

In September, the government finally approved the extension of ARV treatment under the Ministry of Health network. In the second week of November, the first treatments for 160 persons had been decided. At least 40 of them are designated for Roosevelt Hospital users. MSF is also planning to double their ARV treatment cohort in the next year (up to 240 people).

**Potential role of this site in a comprehensive HIV care network:**

This clinic will be essential as a referral and training center for an increase in treatment centers in peripheral hospitals and cities as it has already been considered in the Global Fund proposal.

Persons interviewed: Dr. Carlos Mejia, Head of the AIDS Clinic; Dr. Claudio Ramirez, Head of Internal Medicine Department; Dr. Alberto de Dios, MSF Consultant; Enf. Rosa Sut, Head Nurse of the Clinic; Lic. Ginette Pilate, Microbiologist, MSF Laboratory Consultant

**Clinical site summary sheet  
Infectious Diseases Service of the  
Social Security System  
Guatemala Ciudad, Guatemala  
October 31, 2002**

**Current role in health system:**

The clinic is the main referral center for the peripheral units regarding AIDS and other complex infectious diseases. It has an outpatient clinic, support services, and a hospitalization unit. It cares only for adults. Patients diagnosed with HIV in a peripheral unit are sent to the infectious diseases unit to receive test results and post-test counseling. From that moment, the person is attended in the specialized clinic.

The hospitalization unit has 54 beds. Face masks and hospital coats are required to visit inpatients.

**Current commitment to HIV care:**

In the year 2001, there were 922 persons with HIV; 146 of them were women. In total, they have 1,471 registered persons. Often, new cases present in terminal stages (57 registered deaths in 2002 as of September).

New patients receive a three-week course to prepare for ARV treatment. Once the treatment phase is stabilized, visits occur every two months. The psychologist invites the patients and the patients wait for the medical consultation, for an individual problem, or to continue training on living with HIV. Adherence is a constant worry for staff, but often they have no time to support patients adequately. Social workers may do home visits in selected cases. Low-weight individuals receive nutritional supplements.

The registry and database are not formalized, and it is a complex exercise to produce epidemiological information.

**Current resources available for HIV care:**

*Personnel:* Two physicians for adult care, one resident, one psychologist, one nurse, one social worker, all full time. Also two nurses, 11 auxiliary nurses, one administrator, one secretary and six support members are involved part time.

*Medications:* Most needed drugs are generally available.

*Laboratory:* Social security laboratories are well equipped but sometimes have problems due to lack of certain reagents. CD4 count is done with a FACSCALIBUR machine and is the base for decision making to start treatment. Viral load (NASBA Nuclisens, a new machine as of September 2002) is done only in case of an uncertain CD4 result and only to follow complicated or resistant cases. The actual number of viral load tests is limited to 40 a month for adults.

*ARV agents:* AZT, 3TC, ddI, Indinavir, Nelfinavir, Ritonavir, and Saquinavir were on the basic list. Beginning in 2003, Efavirenz and d4T will be included. The fixed-drug combination of Lopinavir

and Ritonavir will not be included which becomes a problem for people with multi-resistance. It is possible to purchase limited quantities of drugs not on the list, but it is often a complex procedure.

**Planned expansion of HIV care over the next one to two years:**

The Guatemalan Social Security System (IGSS) has come under a strain as the sole provider of ARV therapy since 1998 because ARV drug prices have not been reduced as they have been in El Salvador or Honduras. The AIDS law obliges the IGSS to maintain life-long treatment to PLWHA, even if they are no longer insured. In 2000, a movement to include PLWHA under social security benefits was noted by the authorities who began to inspect the rights to insurance of patients with high-cost diseases. AIDS was one of them, and multiple complaints arose. Some individuals' rights and treatments were suspended in a move to cut costs.

**Potential role of this site in a comprehensive HIV care network:**

The clinic's role remains within the social security system. The present authorities are willing to increase geographical coverage of the system including several new departments but are not willing to contribute to the Ministry of Health efforts beyond sharing common treatment protocols.

Persons interviewed: Dr. Gustavo Castillo, Physician specialized in Infectious Diseases; Lic. Aura Melgar, Psychologist; Lic. Ricardo Garcia and Aida Aguilar, Social Workers; Corina Marroquin, Lab Technician (by phone)

**Clinical site summary sheet**  
**Clínica Luis Ángel García**  
**Guatemala City, Guatemala.**  
**November 4, 2002**

**Current role in health system:**

Since 1988, the clinic Luis Angel Garcia has been run by the private NGO Asociacion de Salud Integral (ASI). It is located inside the General Hospital San Juan de Dios but does not formally belong to it.

**Current commitment to HIV care:**

They offer comprehensive care for PLWHA including voluntary counseling and testing and basic treatment.

The clinic provides outpatient care and procedures to children and adults and follow-up of hospitalized patients. They distribute drugs obtained from donations and do clinical and epidemiological research. They are currently researching TB and fungus and comparing and assessing the quality of different rapid HIV tests. They were also following a cohort of patients with new ARV combinations.

In 2001, they performed 2,991 HIV tests of which 19 percent (573) were positive. They attended 5,335 consultations and 404 new cases of which 281 (70 percent) were in the AIDS phase. In 2000, they attended 727 outpatients and 227 hospitalized patients.

Since 1997, the pediatric clinic (one day a week on the same premises) attended a total of 197 children. Of those, 36 had confirmed HIV/AIDS and another 16 died. In 2000, they attended 137 children in more than 700 visits.

**Current resources available for HIV care:**

*Personnel:* Three physicians, two counselors, two nurses, one pharmacist, and two biologists, as well as support and administrative personnel. For research there are six volunteer students doing their theses each year and four research assistants on a project on TB and fungus. One PLWHA works voluntarily to support the clinic newcomers.

*Medications:* Since 1996, the clinic has been included in a program called Medicinas para Guatemala. They receive U.S. antibiotics and antifungal drugs from this program. They lack Gancyclovir, Folinic acid, Rifabutine, Itraconazole, and Pirimetamine (by itself; they have it combined with Sulfadiazine).

*Laboratory:* The NGO ASI has a basic but complete private laboratory of good quality located close to the hospital that provides a wide range of serologic testing. They have a FACSCOUNT machine for CD4 count, but recently they stopped doing the tests while negotiating a cost reduction from the supplier. They plan to start viral load with NASBA Nuclisens. Up to now, they have paid \$US200 per viral load sending samples to the U.S. Within the scope of research, they have TB and fungal testing.

*ARV agents:* ARV drugs donated from the U.S. program allow treatment for 79 children and 20 adults. Another 50 persons are being treated in a study and by other sources. As drugs are donated, administration depends on the availability. They often receive Protease Inhibitors, but it is more difficult to get Efavirenz or newer drugs. Soon they will get drugs from the government for a group of 80 children and 40 adults.

**Planned expansion of HIV care over the next one to two years:**

This clinic has been chosen as one of the referral centers for the expansion of ARV treatment. It has a well-organized database, a research tradition, and training abilities. Space difficulties are an obstacle to increasing caseloads, but the clinic may move into a bigger area that would allow the team to increase the number of patients seen.

**Potential role of this site in a comprehensive HIV care network:**

Together with the clinic of Hospital Roosevelt, Clínica Luis Ángel García has a clear role as a referral center for complex cases and as a training center to expand the network of services. This clinic is a model for Project HOPE to organize support to the clinic in Hospital Catarino Rivas of San Pedro Sula in Honduras.

Persons interviewed: Dr. Eduardo Arathoon, Head of the Clinic; Lic. Annelise de Salazar, Director of ASI; Lic. Daniel Muralles, Clinic Administrator

**Annex 4:**  
**Notes on the HIV/AIDS Care Settings Situation in Nicaragua**  
**November 2002**

**Existing care settings**

Access to ARV is extremely limited in Nicaragua and is concentrated almost entirely in Managua where there are several physicians with experience in HIV/AIDS care. Several physicians in other cities (Chinandega, León, Bluefields) accept HIV/AIDS patients, but most refer patients who are able to travel to Managua to more experienced specialists. Nicaragua's widespread poverty means the shortcomings of the public health system seriously compromise the quality of care, and the number of patients able to afford care on a private basis is extremely small.

In 2001, the Association of Infectious Disease Specialists (a small group of not more than 10 professionals) developed protocols for ARV treatment in adults and children. The protocols, which have been updated since first released, were developed to fill a void identified by the Ministry of Health, which claimed one reason for not prioritizing the purchase of ARV drugs was lack of capacity at the national level to provide adequate ARV care for AIDS patients.

In the public sector, the Roberto Calderon Gutierrez Teaching Hospital in Managua has been designated by the Ministry of Health as the national referral center for AIDS care for adults. The Manuel de Jesus Rivera Children's Hospital ("La Mascota") provides care for children with HIV/AIDS. At Roberto Calderón, one doctor and one nurse staff an AIDS clinic that operates two mornings per week to provide outpatient care.

The AIDS clinic, established in 1996 by an experienced AIDS care physician who now works in the private sector, currently manages a patient load of approximately 50 patients, two of whom are on ARV therapy. The patient load has increased by more than 200 percent in the past two years, and more than 60 percent have died. Like the rest of the hospital, the AIDS clinic operates under difficult conditions given widespread shortages of supplies and medicines in the public sector. Though the hospital is public, the majority of its laboratory services are provided privately causing problems for those patients without resources to pay for even the most basic tests.

Medications and other supplies of all kinds are similarly difficult to procure. Drugs have been commonly out of stock at virtually every level of the health system, on a national scale for several years, forcing patients to purchase almost all of the items needed for their care. The AIDS Clinic at Roberto Calderón does receive occasional donations of basic drugs appropriate for AIDS patients (antibiotics, antifungal agents, painkillers, etc.) from organizations like MSF and from private donors.

Though the Ministry of Health officially endorses and supports prevention of vertical transmission with an AZT protocol, only two women have been treated in the public sector since mid-2001. Some physicians perceive serious limitations in management capacity within the national AIDS program as major obstacles toward greater communication and collaboration among health care workers at all levels in the public and private sectors, laboratories, and pharmacies.



## **Annex 5:**

### **Pre-service Training Programs Related to HIV/AIDS Comprehensive Care by Country**

#### **Honduras**

##### **The Medical Faculty–The National Autonomous Honduran University**

In Honduras there are only two medical faculties: The Faculty of Medicine of the National Autonomous Honduran University (UNAH) and a new one at the Catholic University in San Pedro Sula which in 2002 began the first year of the medical doctor degree.

The Faculty of Medicine of the UNAH in Tegucigalpa offers the medical doctor degree and the nursing licentiate (bachelor). According to the Faculty of Medicine authorities, the institution has carried out research studies on HIV/AIDS with the participation of students namely HIV/AIDS in rural areas, the relation of HIV and TB, and HIV/AIDS among the Garifuna ethnic group.

The faculty authorities agreed on the need to review the current curricula for medical doctors and nurses recognizing that HIV/AIDS is an increasing problem in Honduras. They expressed their openness to any initiative to review and upgrade the curricula for medical doctors and nurses on HIV/AIDS.

When asked about the possibility of running postgraduate training on HIV/AIDS, they indicated that this should be coordinated with the Postgraduate Directorate of the University and not solely with the Faculty of Medicine.

#### **Panama**

##### **The Faculty of Medicine–National University of Panama**

HIV/AIDS is distributed among the different disciplines of the course namely microbiology, virology, infectious diseases, and internal medicine<sup>108</sup>. Awareness activities conducted in the Faculty of Medicine include the following: KAP studies in the student community (the medical student had conducted KAP studies on fellow students in other faculties); contests for essays on HIV/AIDS; and educational posters for youths. In addition, every year the faculty conducts a two-day course on HIV/AIDS for new medical doctors before they begin their social service. The aim is to introduce capacity to care and treat HIV/AIDS among generalists, gynecologists, and pediatricians, not only infectious disease specialists.

##### **The Faculty of Nursing–National University of Panama**

HIV/AIDS is distributed among different courses. The curriculum emphasizes prevention and risks of HIV/AIDS in the component of community health. HIV/AIDS care is approached in the courses on adult, mother, and child health. Also, HIV/AIDS is discussed in the reproductive health and sexual health courses and in the module for mental health. Lastly, the faculty has integrated the

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<sup>108</sup> Source: Interview with Dr. Marion C. Martin, Dept. of Microbiology of the Faculty of Medicine, University of Panama.

subject of HIV/AIDS into research activities. Fourth-year students conducted a survey on HIV/AIDS in other faculties of the university. At the University Center for Reproductive, Sexual Health and HIV/AIDS, students receive education and promotion for prevention. However, the faculty believes more needs to be done to improve the training in HIV/AIDS to reduce the stigma and discrimination against PLWHA.

The Faculty of Nursing collaborates with other Central American and international nursing schools and faculties for research in El Salvador, Redes de Enfermeras de España, Canada, Venezuela, and Brazil. The faculty also has contact with the Central America and Caribbean Group supported by the Kellogg Foundation on the subject of communication systems.

Currently, Panama has the vice-presidency of the Asociación Latinoamericana de Escuelas y Facultades de Enfermería (ALADEFE). This international institution could facilitate the review and upgrading of curricula through the Unión de Universidades de Latino America (UULA).

#### **Other universities in Panama**

- Latin-American University of Science and Technology offers master's degrees in orthodontia and odontopediatrics (<http://www.ulacit.ac.pa>);
- Universidad Latina offers medical doctor and odontology degrees, and postgraduate degrees in health systems management, tropical medicine, hospital management, and health promotion. (<http://www.ulat.ac.pa/>); and
- Columbus University offers medical doctor degrees (<http://www.columbus.edu>).

### **El Salvador**

#### **Faculty of Medicine–University of El Salvador**

The faculty has started a process of curricula reform that represents a suitable opportunity to upgrade the HIV/AIDS course contents.

The Faculty of Medicine has the medical degree and nine licenciates for nursing, mother and child health, nutrition, etc. In addition there are master's courses on public health and sexual and reproductive health; both have a strong component on HIV/AIDS.

The faculty is planning to start a diploma on sexual and reproductive health using the distance-learning method to cover the 14 departments of the country. The faculty has also conducted a course supported by USAID/CDC on data for decision-making with good results.

#### **Other universities:**

- Evangelic University of El Salvador (UEES) offer medical doctor and odontology degrees ([http://www.uees.edu.sv/acad\\_schools.html](http://www.uees.edu.sv/acad_schools.html));
- Salvadorian University Alberto Masferrer offers medical doctor degrees;
- Private University of Santa Ana, offers medical doctor degrees;
- Centro American University José Simeón Cañas (UCA) offers master's degrees in public health (<http://www.uca.edu.sv/interna/academia/fpre.htm>);

- University Doctor Andrés Bello offers primary qualifications in nursing, clinical laboratory, and technician in radiology and images (<http://www.unab.edu.sv>); and
- University Doctor José Matías Delgado offers medical doctor degrees.

## **Guatemala**

### **The Faculty of Medicine–University of San Carlos Guatemala**

The curriculum for a medical degree is currently under revision, offering a timely opportunity to expand HIV/AIDS training. It was suggested to the team that the USAID regional project should consider a curriculum standard for the region and for the different health professions, with a minimum of requirements all faculties could meet. In this case, the upgrading and/or updating of the curricula would be facilitated at each university in the region instead of starting a diagnostic phase and then proceeding. Faculty members suggested supplying a bibliography, medical journals, or any scientific information for the faculty library as complementary support. The Faculty of Medicine is open to reviewing the curricula for the medicine course as pre-service training.

### **Other universities:**

- Francisco Marroquín University: primary qualifications in psychology, nutrition, medicine, odontology (<http://www.ufm.edu.gt>);
- Mariano Galvez University: primary qualifications in nursing and post-graduate degrees in gynecology and obstetrics; and
- Rafael Landívar University: medium-level nursing, nutrition, optometry, and master's degree in public health (<http://ns.url.edu.gt>).

## **Nicaragua**

### **National University of Managua (UNAN)**

UNAN has a total of 25,000 students and 700 professors in Managua, Estelí, and Matagalpa. There are six research centers (CIES for health-related issues), one related to HIV. They are interested in doing research on evaluation of national AIDS programs, roles of private laboratories, and biosafety.

There are 1,300 medical students enrolled in the faculty and the same number of nursing students at various levels.

In terms of training for health care professionals, HIV/AIDS activities form part of the extracurricular agenda of medical and nursing schools (special topic sessions, lectures, awareness-raising activities with other university faculties, support for the individual, and group research projects at all levels of study). HIV/AIDS topics are included at various points in the curriculum (biosafety, dermatology, virology, pediatric care, etc.).

A recent KAP survey in eight regions among managers of STI/HIV programs at health centers and health posts were acceptable; however, only 40 percent are aware of non-ARV options. They treat many STI, but do not refer cases for HIV testing.

In general, the National University is very interested in HIV/AIDS topics and seeks to ensure professionals graduating from its training programs are adequately prepared to face HIV/AIDS issues.

**Other universities:**

- National University of Leon: pre-grade medicine, pharmacy, psychology, odontology and nursing (<http://www.unanleon.edu.ni>);
- UAM–American University: degree in medicine and odontology (<http://www.uam.edu.ni>);
- Polytechnic University (UPOLI): nursing degree (<http://www.upoli.edu.ni>); and
- POLISAL: offers nursing degree.

**Annex 6:**  
**Postgraduate and In-service Training Programs**  
**Related to HIV/AIDS Comprehensive Care in Central America**

**Honduras**

**San Pedro Sula, Hospital Mario Catarino Rivas.**

In the AIDS clinic, there is no in-service training for HIV/AIDS care. There is one full-time doctor (Dr. Trejo) for HIV/AIDS patients and one part-time doctor (Dr. Alvarado). In this ward there is no rotation for interns and residents. The workload of the two doctors is enormous. Since July when ARV therapy began, there has no been significant support from the hospital to reinforce the staff. The reason given is they cannot increase staff in the health sector.

However, the FORO, Capítulo San Pedro Sula, with the participation of Dr. Trejo, in September started a series of workshops to address the subject of HIV/AIDS comprehensive care and treatment. On September 26-27, a workshop for laboratory staff was held. A second workshop for general doctors on HIV/AIDS comprehensive care and treatment was planned for October 30. The second workshop will address the content of the national guidelines for HIV/AIDS care and treatment<sup>109</sup>.

Dr. Trejo proposed offering a diploma on HIV/AIDS in coordination with the Catholic University, which is running the medical doctor degree program in San Pedro Sula.

**Tegucigalpa–Instituto Nacional del Tórax**

The Instituto Nacional del Tórax (INT) is a national institution dedicated to thoracic pathologies, including those related to infectious diseases. In 1987, in this center, an infection ward to attend HIV/AIDS patients was organized. The clinic has 30 beds, a day hospital and a daily consultation service for outpatients. Two doctors (one infectious disease specialists, as chief of service, one general practitioner trained in ARV therapy in Israel), two social workers, and 6 nursing staff run the clinic. They organized a self-help group of PLWHA and other groups of relatives.

Recently, the hospital authorized the rotation of interns to support the workload and open an opportunity for HIV/AIDS training to new doctors. In addition, Dr. Elsa Palou presented a training project on HIV/AIDS comprehensive care and treatment to the Ministry of Health. Training would be addressed to doctors and other health staff of the regional and area hospitals of the Ministry of Health. The project intends to use the INT to train 12 general doctors, 12 nurses, and 24 nurse assistants in HIV/AIDS comprehensive care, and 12 people in counseling (they could be nurses or social workers). The Ministry of Health has a preliminary agreement with the initiative with the suggestion to elaborate a more comprehensive proposal for the sector<sup>110</sup>.

This setting represents a good opportunity for training national doctors on HIV/AIDS comprehensive care and treatment.

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<sup>109</sup> Source: Interview with Allan Dunaway from the Fundación Llaves, San Pedro Sula – Honduras.

<sup>110</sup> Source: Interview with Dr. Cosenza, Director of Cooperation Office of the Ministry of Health and Dr. Elsa Palou, Chief of Infectology at Instituto Nacional del Torax – Honduras.

### **Tegucigalpa–Hospital Escuela–University Hospital**

The University Hospital designated 18 beds for AIDS patients and a team to care for them composed of one infectious disease specialist, one internist, social workers, and one psychologist. With the approval of 800 new ARV treatments for Honduras, they feel the need to train health workers because of the current low treatment capacity in the health sector. The idea is to reinforce Hospital Catarino Rivas and start ARV therapy in the hospitals of La Ceiba and Tela. The methodology would be to rotate the people identified to sites where there is an ARV therapy unit already established.

### **Tegucigalpa–Honduran Medical Association**

The Honduran Medical Association has a long history; no doctor in the country can practice without its authorization. There are 89 small and local medical associations and 6,100 affiliated medical doctors. In addition, the Honduran Medical Association has a national training program for all the affiliates in which the 89 local associations present a plan each year. They conduct training through small conferences, international conferences, meetings, and short-term courses. They have a training program with credits that accumulate points for application to new jobs.

The Honduran Medical Association expressed interest for training their affiliates in HIV/AIDS comprehensive care and treatment because the country is facing a tremendous epidemic. They are open to supporting and participating in such training<sup>111</sup>.

## **Panama**

### **Faculty of Medicine–National University of Panama and the IPSS**

The University and the Faculty of Medicine have extensive experience conducting postgraduate degrees such as a master's degree in public health, epidemiology, biomedical sciences, and health management, and many postgraduate diplomas on emergency medicine, critical medicine, clinical toxicology, and infectious diseases<sup>112</sup>.

The Faculty of Medicine, in collaboration with the Panama Social Security Institute (IPSS), conducted a diploma course on HIV/AIDS for national doctors. The infectious disease ward of the IPSS has a good standard for HIV/AIDS comprehensive care and treatment, including ARV therapy with well-trained medical doctors and other health staff. The Faculty of Medicine showed interested in organizing courses for the diploma on HIV/AIDS with more comprehensive content. They proposed extending the course content to include management of other infectious diseases in addition to HIV/AIDS.

### **Faculty of Nursing–National University of Panama**

The Faculty of Nursing has a series of postgraduate courses leading to diplomas and master's degrees in care for adults in critical health, in mental health, in health research, and in occupational health, and also offers the international postgraduate degree on mother and child health.

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<sup>111</sup> Source: Interview with Dr. Odessa Henriquez Rivas, President of Honduran Medical Association.

<sup>112</sup> The faculty of medicine has a web site at <http://medicina.up.ac.pa/> for further information

The idea of a diploma in HIV/AIDS comprehensive care and treatment was well accepted by the faculty. They expressed their interest in organizing it in collaboration with the Faculty of Medicine, instead of a course exclusively conducted by that faculty.

### **The IPSS, Santo Tomás Hospital and Hospital del Niño–Panama City**

These three institutions are well organized for comprehensive care and treatment of HIV/AIDS patients, including ARV therapy. The AIDS clinics are run by infectious disease specialists, who were open to receiving international doctors for three months of in-service training.

## **El Salvador**

### **Faculty of Medicine–National University of El Salvador**

The Dean welcomed the initiative to organize a diploma course on HIV/AIDS comprehensive care and treatment, stating the faculty has had good experience organizing and carrying out postgraduate degree courses. The Dean said in order to offer the diploma, it would first be necessary to prepare a curriculum plan, course content, and economic feasibility. The faculty is open to any kind of support for both initiatives: the curricula review and the diploma on HIV/AIDS comprehensive care and treatment<sup>113</sup>.

### **Salvadorian Medical Association**

During our visit, the Salvadorian Medical Association was in the middle of a strike contesting a government decision on the privatization of ISSS services. The Medical Association is currently running a project in the suburbs of the capital to identify HIV-positive pregnant women. They later remit to ISSS or the hospitals of the Ministry of Health. Although the Medical Association used to conduct continuing education for members, the subject of HIV/AIDS was not been considered by the Ministry of Health or by ISSS. The Association holds conferences and meetings for updates in different medical fields, and they would be interested in promoting HIV/AIDS training among affiliates<sup>114</sup>.

### **National AIDS Program: Hospital Rosales, Maternity, Hospital Bloom, and ISSS**

The national AIDS program has already planned the extension of ARV treatment coverage in four departmental hospitals in the country. They are willing to organize a three-month training program including practical aspects in the hospitals already treating adults (Rosales), pregnant women (Maternity), and children (Bloom).

The social security system has its own training program and is preparing for the extension of services.

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<sup>113</sup> Source: Interview with Dr. Ricardo Méndez Flamenco. Dean of Faculty of Medicine, University of El Salvador.

<sup>114</sup> Source: Interview with Dr. Gerber Guzman, Salvadorian Medical Association.

## **Guatemala**

### **Faculty of Medicine–University of Guatemala**

The Faculty of Medicine carries out postgraduate courses including a master's diploma in public health oriented to three specialties: environmental health, epidemiology, and health system management. Other master's courses are in reproductive health and hospital management. The postgraduate courses are self-financed and are organized for distance learning.

The Faculty of Medicine showed interest in offering a diploma in HIV/AIDS comprehensive care and treatment, but they expressed the need to prepare and organize the course and curriculum<sup>115</sup>.

### **Guatemala Infectious Disease Medical Association**

Twice a year, the Guatemala Infectious Disease Association and the Medical Association publish a national medical journal on different subjects including HIV/AIDS. One of the issues of the journal in 2001 was fully dedicated to the protocols for HIV/AIDS comprehensive treatment. The Board of the Infectious Disease Association meets every month to plan, organize, and evaluate the annual action plan for the Association. They have conducted a series of conferences and symposiums in which HIV/AIDS was considered.

When asked to support a diploma on HIV/AIDS comprehensive care and treatment, the president of the association was not convinced it would be a good method for training doctors. He said they could consider themselves specialists on HIV/AIDS, even though they would be, for the most part, general practitioners without any specialized training. He said continuing education through the Medical Association should be reinforced for doctors and should include HIV/AIDS<sup>116</sup>.

The Central American Association of Infectious Diseases is present in the region, but has recently been inactive. It was suggested that support should be given to reactivate it as it represents a good opportunity for infectious disease specialists to network and to exchange technical information.

### **Roosevelt, San Juan de Dios and IGSS Hospitals**

Hospital Roosevelt receives doctors for training for short periods of 15 days. They do not have a formal program for the training sessions but agreed on the need to have a plan including theoretical and practical aspects.

Clinic Luis Angel Garcia in San Juan de Dios Hospital also receives postgraduates for brief visits, but they are mainly from countries outside Central America. Guatemalan doctors do not show an interest in rotating in the clinic. The social security system organizes its own training activities.

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<sup>115</sup> Source: Dr. Cizel Zea, Postgraduate Office, Faculty of Medicine – University San Carlos of Guatemala.

<sup>116</sup> Source: Interview with Dr. Cesar Leonel Gonzalez Camargo, President of Guatemala Infectology Association.

## **Nicaragua**

### **Centro de Investigación y Estudios de la Salud–CIES**

A master's level course in sexual and reproductive health is offered by the Centro de Investigación y Estudios en Salud (CIES), one of the National University's research centers, and includes an HIV/AIDS module.

### **Health Workers**

Gaps in AIDS-related knowledge and attitudes of health care workers are openly acknowledged within the health care system. With relatively few cases reported to date, clinical experience has not accumulated among a large number of professionals. Awareness of and access to HIV testing is not widespread, and people with HIV/AIDS are generally tested at relatively late stages in their disease. Surveys conducted among health workers at a secondary level indicate, while many are aware of HIV and its modes of transmission and prevention, knowledge of treatment options, prevention of vertical transmission and other specific care issues are seriously lacking. Compliance with biosafety measures within the health system and laboratories is limited due to lack of supplies, and is compounded by more generalized attitudes of indifference toward the need to adopt precautions unless a case of infectious disease is clearly denoted as such.



**Annex 7:**  
**Support Settings for People Living With HIV/AIDS in Central America**  
*(by Country)*

**Honduras**

ASONAPVSI DAH is the national network of self-support groups and NGOs of PLWHA. It gathers 24 groups, and this number will increase in the future as more groups and organizations request membership.

Most of these groups work to provide the following:

- counseling;
- education for prevention of transmission and re-infection;
- micro-enterprises to improve family income;
- advocacy for access to care and drugs and defense of human rights;
- training activities;
- adherence to ARV therapy;
- health services at AIDS clinics and health centers;
- education campaigns for adolescents and youth.

Some of them provide direct ARV therapy.

The Comunidad Gay Sanpedrana conducts education projects on prevention for youth. They have a project in which they offer computer training and take the opportunity to talk with youth about HIV/AIDS. They also provide care to the homosexual community and help them find drugs for OIs.

Some groups and NGOs clearly make efforts to offer HIV/AIDS comprehensive care and treatment. They provide OI and ARV therapy and supply them in different ways. Some people buy drugs locally. Some local private companies commit themselves to providing funds to pay for ARV drugs for people, and other drugs come from donations from abroad. But coverage is not enough. For example, Casa Aurora keeps 36 out of 110 children on ARV therapy. They also provide assistance to the family with the idea that children have to be kept at home. They have only a few children at the Casa Aurora because they have no other choice.

Proyecto Puertas Abiertas provides assistance to 140 PLWHA. The group runs a series of projects including micro-credits for micro-enterprises, counseling for adherence to ARV therapy, and ARV therapy for six PLWHA. They receive money from the private sector to buy ARV drugs. They are using generic ARV drugs available on the market. When a person begins Ministry of Health ARV therapy, the treatment passes to another PLWHA. In addition they offer medical care for OIs once a week, and psychological care for counseling twice a week.

Casa San Jose is a hospice for terminally ill persons and people without social or family support. At the time of the visit, there were 11 HIV-positive and four HIV persons admitted. They have a self-support group called “La Fuerza de Jospice”, which helps to gather needed funds to sustain the

hospice. They have organized a regular supply of food and non-food items from local companies in San Pedro Sula. Other organizations oversee repairs and rehabilitation of the building. Jospice International is a British-based religious organization that regularly covers certain basic expenses.

In Tegucigalpa, the Asociación Hondureña Solidaridad y Vida offers ARV therapy, medical care for OIs, psychological assistance, and support for micro-enterprises to improve family income.

Some NGOs concentrate efforts on advocacy for access to ARV treatment and comprehensive care and defense of human rights. One of them is Fundación Llaves, which edits a monthly magazine on PLWHA actions and on progress toward ARV treatment in the country. One of its members, Rosa Gonzalez, made a crucial intervention in Parliament with positive results. The government authorized the purchasing of ARV drugs for at least 1,000 people. An area that has been neglected is the violation of human rights in the work place. Employers require that workers be tested for HIV as requisite to hiring.

## **Panama**

PROBIDSIDA, an NGO of PLWHA, advocates for access to ARV therapy and comprehensive health care, defends human rights in the work place and organizes prevention and education activities. The organization worked closely with the Faculties of Medicine and Nursing to organize conferences and to present personal PLWHA experiences to sensitize future health workers. They also have a hotline called “Linea de Auxilio” for counseling and education.

PROBIDSIDA played a definitive role in ARV access in 1998 when they started an ARV access campaign using demonstrations and political pressure aimed at government and social security services. They plan to have a laboratory for HIV detection and a counseling clinic. PROBIDSIDA considers it necessary to have legal support to fight employers who dismiss workers because they are HIV-positive.

## **El Salvador**

FUNDASIDA is an NGO which offers medical care for OIs and a hospital day service open to 5 p.m., home visits, and psychological and emotional assistance. It also conducts education and prevention activities. They followed 507 patients and carried out 1,690 consultations from January to September 2002. They have delivered more than 15,000 condoms monthly at universities. Also, FUNDASIDA has a “Linea Confidencial” with 1,732 calls this year, even though the people calling have to pay for the call. They also have a radio program, with more than 100 messages daily paid for by private companies. The Dutch government was the major donor for their programs, but the financial support ended in August. FUNDASIDA participates in the UNAIDS theme group and represents the Red PrevenSIDA.

ATLACATL is the only organization of PLWHA organized outside the health system. Their main activity is to defend the human rights of PLWHA. The right to work is one of their main activities. They have undertaken legal action to request universal ARV access to work for PLWHA. They

also give high priority to issues such as respect and confidentiality among health staff regarding the serostatus of their patients and to mistreatment and discrimination. They are organizing the creation of autonomous self-support groups in other departments of El Salvador. A board of directors for PLWHA was being organized at the time of the visit. If it develops, it will be a fundamental body to organize and implement comprehensive care and support actions within the community and family levels of the Building Blocks strategy.

## **Guatemala**

In Guatemala, the Coordinadora de Sectores de Lucha Contra el SIDA coordinates 33 NGOs and several other organizations from different sectors of society. The Coordinadora and the Fundación Fernando Iturbide support PLWHA for ARV therapy at the IGSS and submit legal injunctions when the PLWHA do not receive appropriate laboratory diagnostic support or do not receive second-line ARV therapy when necessary.

Gente Positiva is the oldest NGO of PLWHA in Guatemala and has about 300 users. They concentrate on aspects of quality of life for PLWHA. This includes defense of human rights (respect, solidarity, and non-discrimination). They try to empower informal groups and PLWHA to support demands for universal access to ARV treatment and work to eliminate discrimination. They provide psychological therapy and emotional support on an individual and family basis. They also provide nutritional training, food support, and a drug bank to complement needs of medication for OIs and sometimes ARV. Gente Positiva is closely linked with the Roosevelt Hospital clinic and the MSF team, providing support services to clinic patients.

Asociación Gente Nueva runs programs to provide HIV/AIDS comprehensive care and treatment. They have a professional staff consisting of one doctor, one dentist, one psychologist, one social worker, one nurse, and one communication specialist. The organization offers medical care for OI and ARV therapy to 27 people, as well as dental care, counseling in coordination with ASI clinics, psychological therapy, lodging for people coming from other departments of the country, and educational and informational programs for prevention. They receive government financial support to purchase drugs and pay professional staff.

## **Nicaragua**

Because so few patients can afford to buy medications, doctors in both the private and public sectors refer their patients to several local NGOs that manage private donations of medicines (Fundacion Nimehautzin, Fundacion Xochiquetzal, Proyecto HOPE, MSF, and others). Depending on available resources, these NGOs, as well as the Nicaraguan Association of People Living with HIV/AIDS, also provide psychosocial and sometimes financial support (education stipends for children, food, etc.) to PLWHA and their families.

Unfortunately, AIDS continues to be highly stigmatized in Nicaragua, and, given the multitude of other health crises facing the country, it is unlikely to become a top priority of the Ministry of

Health in the near future. This stigma is reflected in the silence that surrounds the epidemic, which is reflected at every level. These include the following:

- Individuals who are afraid to learn their serostatus and to speak publicly about it (including many who are active in PLWHA support groups)
- Families who reject infected members
- Employers who dismiss workers discovered to be HIV-positive
- Health care workers who cannot recognize AIDS symptoms or those who refuse contact with known patients
- Government policies that do not recognize the opportunity for awareness-building and prevention, especially among youth

There are recent signs of greater receptivity in government circles marked by Nicaragua's submission of a proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Round 2), which included a significant care component to treat up to 400 people by the fifth year of the project. The proposal also includes capacity building for health care professionals in various areas of HIV/AIDS. News on approval of the project is expected in early 2003.

**Annex 8:**  
**Directory of Self-Support PLWHA Groups and NGOs**  
**Involved in the Fight against HIV/AIDS**

**Honduras**

**ASONAPVSI DAH:**

**National Association of People Living with HIV/AIDS in Honduras**

A self-help group in itself, this association has been in charge of organizing national meetings of other groups of PLWHA. They had a crucial role in promoting their organization and pushing their demands forward.

**Self-help groups belonging to ASONAPVSI DAH:**

- **San Pedro Sula:** Ministerio Siempre Unidos, Esperanza de Vida, Juntos por la Vida, Viviendo con VIH, Programa Puerta Abierta, Red de Mujeres Positivas, Red de Hombres Positivos, Fundación Llaves, La Fuerza de Jospice, Plan 20.
- **Tegucigalpa:** Renacer, Buen Samaritano, Tórax, Casa Pasionista, Solidaridad y Vida, Fundasida.
- **Others:** Rompiendo Cadenas, La Ceiba; Unión y Esperanza, Tela; Génesis, Puerto Cortés; Comluvis, Siguatepeque; Cáritas, Siguatepeque; Amor, Fe y Esperanza, Comayagua; Más que Vencedores, Choluteca; Ebenezer, Progreso.
- There are other groups interested in belonging to ASONAPVSI DAH, from Choluteca, Danlí y Juticalpa.

**Comunidad Gay Sanpedrana**

2a. Calle, 8 y 9 Ave., # 67, San Pedro Sula

**Proyecto AKULEL**

Barrio Lempira, 9a. Calle, 8 y 9 avenidas, No. 29, San Pedro Sula

**Casa Aurora**

Col. Aurora 7, Calle B, 14 y 15 Ave., S.E., zona 9, #1494;  
última calle de Col. Aurora, contigua a campo de Timbal, San Pedro Sula

**Fundación Solidaridad y Confraternidad**

Ave. Junior, 9 y 10 calle; 4ta. Av. #3, frente a Escuela Soledad Fernandez, San Pedro Sula

**La Fuerza de Jospice**

Col San Vicente de Paul, frente a Fabrica de Boquitas Rica Sula, San Pedro Sula

**Asoc. Hondureña Solidaridad y Vida**

Col. Alameda, tres casas al Norte de Rescate Medico Movil, Casa #734 Tegucigalpa

## **Panama**

### **PROBIDSIDA**

Calle 31 con Ave. Balboa, entre Restaurante. Boulevard y gasolineras DELTA, al frente de Multiaire de Panama. e-mail: [probridsida@cwpanama.net](mailto:probridsida@cwpanama.net)

### **Movimiento Activista Para la Prevención del SIDA MAPSIDA**

Ancón, Gamboa (Entrega General), Panama.

Tel: (507) 276 6209, e-mail: [grupomapsida@hotmail.com](mailto:grupomapsida@hotmail.com)

### **Nueva Era en Salud**

Apdo. 6-655 El Dorado, Panamá

Tel: (507) 225 0418, e-mail: [carmen@nueva-era.org](mailto:carmen@nueva-era.org)

### **Cruz Roja Panameña**

Albrook, Ed. 253 Area Revertida

Tel: (507) 315 0456, e-mail: [busqueda@sinso.net](mailto:busqueda@sinso.net)

### **Asociación Panameña para el Planeamiento de la Familia, APLAFA**

Clayton / Calle Jocker, Corregimiento de Ancón, Oficinas. 10001 C y D, Panamá.

Tel: (507) 317 0429, e-mail: [aplafa@orbi.net](mailto:aplafa@orbi.net)

### **Asociación Nacional para el Desarrollo de la Salud Comunitaria ANADESAC**

Calle 33 Av. Cuba, Panamá.

Tel: (507) 227 1527, e-mail: [maribelcoco@hotmail.com](mailto:maribelcoco@hotmail.com)

### **Asociación Hombres y Mujeres Nuevos de Panamá, AHMNP**

Apto. 87-0002, Panamá 7, Panamá.

Tel: (507) 230 6586, e-mail: [ahmnp@yahoo.com](mailto:ahmnp@yahoo.com)

## **El Salvador**

### **FUNDASIDA**

23 calle poniente No.1037 Col. Laico, San Salvador  
Tel: 222-4545 Cel: 887-1818, e-mail: [fundasida@salnet.net](mailto:fundasida@salnet.net)

### **Atlacatl**

Calle El Progreso Reparto Rosedal Pje., El Rosal Casa No. 1., San Salvador.  
Tel: 298-3950,5801, e-mail: [odirmirandasv@msn.com](mailto:odirmirandasv@msn.com)

### **Asociación de Mujeres Flor de Piedra**

9a. Calle oriente No. 920, San Salvador  
Tel: (503) 222 3951

### **Entre Amigos**

Asociación Salvadoreña de DDHH para Homosexuales, Lesbianas y Bisexuales.  
Avenida Santa Mónica No. 171 Urbanización Buenos Aires 4, San Salvador  
Tel: (503) 257 4929, Fax: (503) 257 4929, e-mail: [william2401@yahoo.com](mailto:william2401@yahoo.com)

### **Equipo contra el SIDA–El Salvador**

Calle Las Animas No. 46 Barrio Paleca, Ciudad Delgado, San Salvador  
Tel: (503) 276 2235, e-mail: [aidsno@es.com.sv](mailto:aidsno@es.com.sv)

### **Fundación Olof Palme**

Calle 4 No. 114 Colonia El Roble, San Salvador.  
Tel: (503) 225 4138, e-mail: [fundolofpalme@salnet.net](mailto:fundolofpalme@salnet.net)

### **G.T.Z. Salud Reproductiva**

Residencial México Edificio "E" Apto. 8 Mejicanos, San Salvador.  
Tel: (503) 225 5140

### **Medicos Sin Fronteras**

Avenida Principal "B" casa 5-f Paj. No.3 Residencial Palermo, San Salvador.  
Tel: (503) 224 2983, e-mail: [msfaids@telesal.net](mailto:msfaids@telesal.net)

### **Visión Mundial El Salvador**

Avenida Bernal Número 222, Colonia Miramonte, San Salvador.  
Tel: (503) 260 0565, E-mail: [el-salvador@wvi.org](mailto:el-salvador@wvi.org)

### **Plan Internacional de El Salvador**

Avenida Las Palmas Número 125, Colonia San Benito San Salvador.  
Tel: (503) 245 5053, e-mail: [henriquilm@plan.geis.com](mailto:henriquilm@plan.geis.com)

### **Save the Children/DIC**

35 Avenida Sur #626, Colonia Flor Blanca, San Salvador.  
Tel: (503) 298 9111 / 12 / 14, e-mail: [save\\_programa@ejje.com](mailto:save_programa@ejje.com)

## **Guatemala**

### **ACSLCS Asociacion Coordinadora de Sectores de Lucha Contra el SIDA**

10a. Calle 4-86, zona 10, Interior.

Telefax: 3324140, e-mail: [acslcs@intelnet.net.gt](mailto:acslcs@intelnet.net.gt)

This is the main body, which integrates most of the Guatemalan organizations with specific activities against HIV/AIDS. It includes governmental and religious organizations, NGOs, and groups of PLWHA. A list of members and their addresses follow.

### **Organizaciones No Gubernamentales**

#### **Asociación Guatemalteca de Educación Sexual (AGES)**

7a. Calle 3-67, Zona 1, Guatemala 01001

Telefax: 2328334, 2937322, 2937751, e-mail: [ages@explonet.com](mailto:ages@explonet.com)

#### **Asociación Guatemalteca de Mujeres Médicas (AGMM)**

Calz. Roosevelt, Km.6.5, Z.11 (INCAP)

Teléfono: 4409742, e-mail: [karina3@intelnet.net.gt](mailto:karina3@intelnet.net.gt)

#### **Asociación de Salud Integral (ASI)**

1a. Ave. 11-19 Zona 1, Guatemala 01001

Tel: 220-8506-08-11 / 253-2219. Fax : 251-6531, e-mail: [asiagpcs@intelnet.net.gt](mailto:asiagpcs@intelnet.net.gt)

#### **Asociación Pro-Bienestar de la Familia de Guatemala (APROFAM)**

9a. Calle 0-57 Zona 1, Guatemala 01001

Tel: 230-5488/90 - 230-5492 y 94 Ext. 115. Fax: 251-4017, e-mail: [aprofam@guate.net](mailto:aprofam@guate.net)

#### **Casa San José**

Lotes 3 y 4, 1a. Ave. y 1a. Calle, Residenciales Los Alpes, San Lucas Sacatepéquez

Telefax: 830-4066, e-mail: [jospice@mixmail.com](mailto:jospice@mixmail.com)

#### **Centro de Desarrollo Humano de Guatemala**

5a. Calle 2-80 Zona 1, Guatemala 01001

Telefax: 232-7411, e-mail: [humano@intelnet.net.gt](mailto:humano@intelnet.net.gt)

#### **Dirección General de Investigación**

Edificio S-11, 3er. Piso - Ciudad Universitaria Z.12

Tel: 4767213 y 4767239. Fax: 4769675 y 4767232, e-mail: [usacdigi@usac.edu.gt](mailto:usacdigi@usac.edu.gt) ; [puiis@usac.edu.gt](mailto:puiis@usac.edu.gt); Hoja Web: <http://www.usac.edu.gt/dir-grales/digi/>

#### **Fundación Marco Antonio**

5ª. Av. 8-33 zona 4, Guatemala 01004

Tel: 3344752, 3345059. Fax: 3345438, e-mail: [fundamaco@intelnet.net.gt](mailto:fundamaco@intelnet.net.gt)

**Fundación Preventiva del SIDA "Fernando Iturbide"**

10ª calle 4-86 Zona 10, Ciudad de Guatemala 01001

Tel: 3323350. Telefax: 3311698, e-mail: [fundsida@inteln.net.gt](mailto:fundsida@inteln.net.gt)

**Asociación Gente Positiva**

6ª. Av. 1-73 zona 1, Guatemala 01001

Tel: 2501033 y 2322807. Fax: 2204998, e-mail: [info@gentepositiva.org.gt](mailto:info@gentepositiva.org.gt)

**Instituto de Educación Integral para la Salud y el Desarrollo (IDEI)**

7a. Calle 4-24, zona 1. Quetzaltenango, Guatemala C.A.

Tel: 7619419. Telefax: 7614280, e-mail: [idei@guate.net](mailto:idei@guate.net)

**Organización de Apoyo a una Sexualidad Integral frente al SIDA (OASIS)**

Apartado Postal 1289, 6ª. Avenida 1-63 zona 1, Guatemala 01001

Tel: 2533453 y 2201332. Fax: 2321021, e-mail: [oasisgua@inteln.net.gt](mailto:oasisgua@inteln.net.gt)

**Asociación Rxiin Tnamet**

Cantón Xechivoy, Santiago Atitlán, Sololá Guatemala, C.A.

Telefax: 7217246, e-mail: [rxiiin@guate.net](mailto:rxiiin@guate.net)

**Sector Estatal**

**Centro de Atención a las Infecciones de Transmisión Sexual**

26 calle 5-43, zona 3, Guatemala 01003

Tel: 471-2280. Fax: 4722354.

**Comité de Educadores para la Prevención del SIDA (COEPSIDA)**

2a. calle 6-51, zona 2, Guatemala 01002

Tel: 2516595/2383965. Telefax 2209080, e-mail: [coepsidameduc@hotmail.com](mailto:coepsidameduc@hotmail.com)

**Dpto. de Psicología de la Dirección General del Sistema Penitenciario**

7ª. Calle 10-54 Zona 1, Edificio El Imparcial 3ª. Nivel, Guatemala 01001

Tel: 2534401-02. Telefax: 2534401.

**Procuraduría de los Derechos Humanos**

12 av. 12-72 zona 1

Tel: 2300874, 75 y 76, e-mail: [opdhg@inteln.net.gt](mailto:opdhg@inteln.net.gt)

**Servicio de Sanidad Militar**

Acatan, Sta. Rosita, zona 16, Guatemala 01016

Tel: 261-0358/60/62. Fax: 261-0363.

**Hospital Roosevelt**

Calzada Roosevelt y 8ª. Av., zona 11, Colonia Roosevelt.

Tel: 4711441 y 4711443, jefatura medicina interna, e-mail: [carlosmejia@guate.net](mailto:carlosmejia@guate.net)

## **Sector Religioso**

### **Programas y Proyectos del Arzobispado de Guatemala**

Oficina de Pastoral Social del Arzobispado, 7a. Ave. 4-28 Zona 1, Guatemala 01001

Telefax: 2200098, e-mail: [opsagvihsida@c.net.gt](mailto:opsagvihsida@c.net.gt)

### **Clínica Médica Parroquial**

2ª. Avenida 2-75 zona 1, Tecun Uman, Guatemala.

Teléfono y fax: 7768955.

### **Proyecto Vida**

Coatepeque

Tel: 7750812.

## **International Organizations**

### **Médicos Sin Fronteras**

5ª. Calle "A" 1-57, Zona 3, Guatemala 01003

Tel: 232 9685. Fax: 2200556, e-mail: [esidamsf@intelnet.net.gt](mailto:esidamsf@intelnet.net.gt)

### **PASMO**

13 calle 3-40, Zona 10, Edif. Atlantis, 8o nivel, of. 804, Guatemala 01010

Tel: 366-1557/59. Fax: 366-1567, e-mail: [pasmo@pasmo.com.gt](mailto:pasmo@pasmo.com.gt)

### **CRS, Catholic relief Services**

1ª. Ave.10-57 zona 10.

Tel: 3310285/3323264/3310603.

### **Christian Children's Fund**

Av. Reforma 7-62, zona 9 Edificio Aristos Of.201

Tel: 3851812/3851819. Fax: 3851821, e-mail: [ccfguate@intelnet.net.gt](mailto:ccfguate@intelnet.net.gt)

### **Desarrollo Integral del Niño de Escasos Recursos -DINER-**

11 Ave. Independencia 5-38, zona 2.

Tel: 2890285-2544405. Fax: 2702453, e-mail: [diner@terra.com.gt](mailto:diner@terra.com.gt)

### **Plan Internacional**

Ave. Reforma 6-64, zona 9, 6to. Nivel, Plaza Corporativa

Tel: 3391462. Fax: 3391455.

## **Ingresos Recientes**

### **Cruz Roja Guatemalteca**

3a. Calle, 8-40 zona 1

Telefax: 2324648-2324649

E-mail: [crgjuventud@intelnet.net.gt](mailto:crgjuventud@intelnet.net.gt) ; [crg@intelnet.net.gt](mailto:crg@intelnet.net.gt)

**Proyecto VIH/SIDA “Asoc. Ak’tnamit**

Apartado Postal #2675-Ciudad de Guatemala, Aldea Barra de Lámpara – Livingston, Izabal  
Telefax: 9083322. Tel: 9084358.

**Asociación Gente Unida**

Coatepeque  
Telefax: 7750812.

**Asociación Guatemalteca de Enfermedades Infecciosas**

Ciudad de Guatemala  
Tel: 3350545.

**Asociación de Químicos Biólogos de Guatemala**

0 calle 15-46, zona 15. Col. El Maestro, Edificio de los Profesionales III Nivel  
Tel. 3693675, 3693676. Fax: 3658803.

**Organizations not belonging to the ACSLCS**

**Asociación Gente Nueva**

1a. Ave 9-33, zona 1  
Tel: 253-9150.

**APAES Solidaridad**

## **Nicaragua**

### **Comisión Nacional de Lucha contra el SIDA desde la Sociedad Civil, CNLS**

Edificio El Carmen, del canal 4 TV, 1/2 cuadra al Sur. Managua

Tel: (505) 266 0718, e-mail: [ceps@ibw.com.ni](mailto:ceps@ibw.com.ni)

### **Fundación Nimehuatzin**

Reperto Lomas de Guadalupe, portón principal UCA 1 cuadra al este, 1 ½ al Sur No. 68. Managua.

Tel: (505) 278 0028.

### **Fundación Xochiquetzal**

Cuidad Jardín Itr 1 ½ al Sur No. 8. Managua.

Tel: (505) 249 6190, 249 0585.

### **Asociación "Mary Barreda"**

Banco Nicaraguense, 1/2 cuadra Este, León.

Tel: (505) 311 2259, e-mail: [marybarreda@unanleon.edu.ni](mailto:marybarreda@unanleon.edu.ni)

### **Asociación de Mujeres Nicaraguenses "Luisa Amanda Espinoza"**

Reperto San Juan. Entrada principal 2 1/2 cuadras al Sur, Managua.

Tel: (505) 277 3598 / 1661, e-mail: [amnlae@cable.net.com.ni](mailto:amnlae@cable.net.com.ni)

### **Asociación Nicaraguense VIH/SIDA o Gente Positiva**

Licorería Don Bosco 2 1/2 cuadras al lago, casa No. F-355 mano izquierda Managua.

Tel: (505) 248 2364, e-mail: [cepresi@ibw.com.ni](mailto:cepresi@ibw.com.ni)

### **Campaña Costeña Contra el SIDA**

Barrio Santa Rosa, junto a la casa del doctor Donald Weill Bluefields.

Tel: (506) 822 1912, e-mail: [bettaman@ibw.com.ni](mailto:bettaman@ibw.com.ni)

### **Centro de Estudios y Promoción Social (CEPS)**

Edificio El Carmen, del canal 4 TV, 1/2 cuadra al Sur Managua.

Tel: (505) 266 0718, e-mail: [ceps@ibw.com.ni](mailto:ceps@ibw.com.ni)

### **Centro de Información y Servicios de Asesoría en Salud. CISAS**

Del canal 2 de TV, 2 cuadras al Sur, 75 varas abajo Managua.

Tel: (505) 266 1662, e-mail: [educador1@cisas.org.ni](mailto:educador1@cisas.org.ni)

### **Centro para la Educación y Prevención del SIDA. CEPRESI**

Licorería Don Bosco, 2 cuadras al lago, casa F-355 Managua.

Tel: (505) 248 2364, e-mail: [cepresi@ibw.com.ni](mailto:cepresi@ibw.com.ni)

### **Médicos Sin Fronteras**

Del Hotel Mansión Teodolinda, 20 varas al lago. Managua

Tel: (505) 222 3531 / 32, e-mail: [comed@ifxnw.com.ni](mailto:comed@ifxnw.com.ni)

**Organización Panamericana de Mercadeo Social. PASMO**

Puente El Edén, 2. 1/2 cuadra arriba. Comercial Periferico, modulo 4 Managua

Tel: (505) 249 3661 3662, e-mail: [pasmoic@tmx.com.ni](mailto:pasmoic@tmx.com.ni)

**NICASALUD**

Carr. a Masaya, semáforos Bancentro 1 Cuadra E, 1/2 cuadra S. PO Box 3084. Managua.

Tel: (505) 278 2268, e-mail: [nsalud@nicasalud.org.ni](mailto:nsalud@nicasalud.org.ni)

**Servicios Integrales para la Mujer. SI MUJER**

Reperto El Carmen, Edificio IBM Montoya, 1/2 cuadra arriba. Managua.

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## **Annex 9:**

### **Suggested Indicators for Intermediate Result 3**

#### **STRATEGIC OBJECTIVE 8: THE HIV/AIDS PROBLEM IN CENTRAL AMERICA CONTAINED AND CONTROLLED**

- *HIV prevalence among 15-49 year olds in low prevalence countries.*
- *HIV prevalence rates among those 15-24 years of age in high prevalence areas within the region.*
- *Percentage of infected mothers who have access to interventions to reduce HIV transmission to their infants, in high prevalence areas within the region.*

#### **INTERMEDIATE RESULT 3 for SO3 (8.3): Effective and efficient delivery of Comprehensive Care for People Living with HIV/AIDS**

- *Percentage of HIV-infected persons provided with basic care and psychological support, in high prevalence areas within the region*
- *Percentage of children affected by AIDS provided with community support services, in high prevalence areas within the region*

#### **SUB INTERMEDIATE RESULTS FOR IR3 (8.3.1-3)**

##### **1. Sub Intermediate Result for IR3 (8.3.1): Best practices appropriate to the local resources available for comprehensive care system developed and applied.**

**Low-level result 8.3.1.1:** At least one tertiary care center in each country, with experience in HIV care, designated as a training center for health professionals and prepared to support the expansion of the comprehensive care network into the primary and secondary levels of the health system.

- *Existence of comprehensive HIV/AIDS care and support policies, strategies and guidelines in line with current PAHO, WHO or International Standards.*
- *Number of graduates of medical, paramedical and related training institutions in the past 12 months who have received and completed formal training in HIV diagnosis, care, support and treatment, following the program designed for in service training in the tertiary clinics supported by USAID.*
- *Number of references and counter-references of HIV infected persons, between the USAID supported tertiary clinics and the secondary and primary health centers included in their formal network of services.*

**Low-level result 8.3.1.2:** A network of trainers/supervisors, with practice in the tertiary level, prepared to reinforce the comprehensive care and support strategy within the health system, is established.

- *Number of trainers/supervisors fully trained and active at the end of each FY. Activity will be measured by the number of supervision visits.*

**Low-level result 8.3.1.3:** At least one or two STI/HIV/AIDS clinical centers, linked to the tertiary training centers are developed in each country, to extend coverage of high quality prevention, care and support services throughout the health system and the community.

- *Number of individuals with advanced HIV infection receiving ARV therapy in each USAID supported clinic.*
- *Number of confirmed or suspected HIV-infected individuals cared for by each health facility supported by USAID in the last year.*
- *Number of individuals receiving Voluntary Counseling and Testing in each USAID supported clinic.*

**Low-level result 8.3.1.4:** A network of community organizations, NGOs and groups of PLWA is prepared to complement the health system by creating innovative approaches to address medical, social and psychological needs of people infected and affected by HIV.

- *Number of individuals reached by community and home-based care programs in the past 12 months.*
- *Number of individuals reached by the organizations in Hospitals, clinics and other institutional services.*

**Low-level result 8.3.1.5:** An operations research study, following a prospective cohort of treatment naive HIV infected individuals placed on ARV therapy in the comprehensive care centers, demonstrates immunological and clinical benefits.

- *Percent of people from the cohort with more than 200 CD4/ $\mu$ l at 6 months and then yearly that started ARV treatment with less than 200.*
- *Case fatality rate in the cohort, per CDC clinical stage (A,B,C) at 6 months and then yearly.*
- *Percent of people discontinuing ARV therapy each year.*

**2. Sub intermediate result 2 (8.3.2): A comprehensive HIV/AIDS training and mentorship program for health professionals is developed and implemented in each country.**

**Low-level result 8.3.2.1:** Pre-service training curricula for health professionals on HIV/AIDS comprehensive care and treatment is upgraded, updated and implemented in schools and universities.

- *Number of schools and universities effectively training in Comprehensive care, effectiveness will be measured as the number of persons fully trained according to each program.*

**Low-level result 8.3.2.2:** An international network is established among trainers and specialists on HIV/AIDS to standardize a regional approach.

- *Existence of an active network. Activity will be measured by the number of members and their output in common documents and programs.*

**Low-level result 8.3.2.3:** A training program structured to train members of the health team in comprehensive care centers, is designed, implemented and evaluated.

- *Existence of a regional training program approved by PAHO.*
- *Proportion of workers of the health centers and clinics supported by USAID that finished their training program each year.*
- *Proportion of centers applying the program evaluated and application of proposed improvements.*

**Low-level result 8.3.2.4:** A diploma in STD/HIV/AIDS and other priority infectious diseases (covering care, treatment, management and public health aspects) is promoted, developed and utilized in the region.

- *Existence of a curriculum developed for training*
- *Number of institutions applying this curriculum.*
- *Number of persons that get the diploma title each course.*

**3. Sub intermediate result 3 (8.3.3): Selected groups of PLWA, community organizations and NGOs supporting treatment and integration of PLWA back into society.**

**Low-level result 8.3.3.1:** PLWHA are included as beneficiaries in existing systems to provide food support and nutritional training.

- *Number and percent of PLWA benefiting from nutritional support in existing and new programs.*

**Low-level result 8.3.3.2:** A program to help find jobs for PLWHA is set up and in use in each country, including training and education, micro credits, small businesses creation and active job search.

- *Number of individuals reached by the program each year.*
- *Number of persons who found employment through the program and keep it after at least six months.*

**Low-level result 8.3.3.3:** Legal advice and defense to PLWHA about working problems with employers is available through at least one group per country.

- *Number of legal injunctions presented, percent of those resolved, and percent of those resolved favorably for the demanding persons—including those resolved by out of court negotiations.*